MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 27TH JUNE 2024 - DAY 99

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THE INQUIRY RESUMED ON THURSDAY, 27TH JUNE 2024 AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you.

MS. BERGIN: Good morning, Chair and Panel. We're picking up on the evidence of H189. 09:51

H189, CONTINUATION OF EXAMINATION BY MS. BERGIN

MS. BERGIN: If we can begin at paragraph 83 of the statement, please. So, good morning, H189. 09:51

A. Morning.

1 Q. Yesterday before we concluded your evidence we were dealing with the issues around seclusion and MAPA and we were coming on to PRN, so that's where we're going to pick up, all right. So looking at paragraph 83, here you say that you had discussions with ward staff from other wards wanting to use ICU seclusion, and in this paragraph you deal with preventing the use of seclusion, and you say that you were encouraging staff to think differently about the use of ICU seclusion, for example, by going for a walk, and you say: 09:52 09:52

"Sometimes a patient in crisis requested seclusion or PRN and they were immediately better. This is not physiologically possible and sometimes it was about Muckamore staff reflecting on treatments. Sometimes it was about the psychological impact of a restriction and that it created something of a placebo effect and for a 09:52

patient it rounds off a period of distress."

Why do you say it was not physiologically possible? Can you explain that, please?

A. Yes. I suppose when we talk about some of the medications that might have been given as PRN medication... 09:53

Q. Sorry to interrupt you. If I can ask you maybe just to either pull the microphone close to you and just raise your voice just a little bit? 09:53

A. Okay.

Q. Thank you.

A. So when we consider some of the medications that would have been given as PRN medication, diazepam for example, the time for that to become effective and be processed in the person's body, it wouldn't have been within five minutes. So actually seeing people getting a PRN diazepam, or PRN Lorazepam, and settling instantly, it indicated that it was not the actual medical effect of the tablet, it was more the receiving the tablet which was having that effect on the person. I suppose I recall then seeing that as a way of trying to find alternatives, I'm thinking of an experience with one patient on that, and seeing that as a way of a person actually asking for help without having the ability to ask for help, but they were asking for their PRN medication. So I know we worked with our behaviour nurse about trying to provide that person with Cue Cards so that they could indicate whenever they were 09:53 09:53 09:54

feeling distressed, as opposed to asking for medication.

4 Q. In terms of this paragraph, you're discussing I suppose your work with staff members from other wards trying to reduce or prevent the use of seclusion. Was there something in particular that prompted this engagement with staff or how did this come about? 09:54

A. I think in general it followed on from the delivery of the MAPA training and thinking about how you supported people who were in crisis, and there was nothing in the training that would have enabled really somebody to move from another ward to walk across a site, voluntarily walking through a door and then go into a seclusion room, and it was trying to think in terms of if the person is able to do all of them things, do they really need to use the seclusion facility at the end of it? And then thinking of the steps in between. So if the person is able to go for a walk -- if they're able to walk from a ward to a seclusion room, are they able to go for a walk from a ward to somewhere else around the site? 09:54 09:55 09:55

5 Q. Given the advice that you were giving to staff about how to, or trying to avoid seclusion, do you think that seclusion was being sufficiently avoided?

A. I think staff did try to avoid it, yeah. And I think it was sufficiently avoided. 09:55

6 Q. If we could then look at paragraph 99, and I want to go on to PRN now, and here you say:

"The use of PRN medication was reviewed as part of the MDT meetings and the information was included in the monthly updates. This information was also gathered by H777 and included in her reports."

09:56

And later on, and we don't need to go to it, but later on in your statement you also refer to PRN medication at paragraph 131, where you outline that it was administered as having been prescribed on the patient's Kardex first, and that it was monitored through the clinical team via MDT meetings. 09:56

So when you say here that PRN was reviewed as part of MDT meetings, do you mean that each and every use of PRN was discussed at an MDT meeting, or do you mean it was just generally discussed as a topic? 09:56

A. I think it would have been generally discussed as a topic. So it wouldn't have reviewed each and every use of PRN medication, it would have been a lookback over the previous week, and if there was perhaps an increase in the frequency of it being administered. 09:57

7 Q. Do you mean to a specific patient or on the ward generally?

A. To a specific patient.

8 Q. Okay. 09:57

A. At clinical ward level, and I suppose the wider governance level looking at a wider thematic use of PRN across the site.

9 Q. And we discussed yesterday the, I suppose the

improvements, perhaps, that were made in light of transferring some of the records on to Datix. Do you know in terms of the analysis of PRN medication, is that something then that the Datix system is also used for? 09:57

A. I'm not sure if Datix picked up PRN medication. I think there was a tick box at the bottom to indicate if -- I think PRN was also part of the field of seclusion. So if physical intervention was not successful or, I can't recall exactly how it was worded, what other 09:58 interventions were attempted, and I think PRN might have been a tick on that. I'm not sure how that was retrieved for reporting on. It might still have been a manual report in terms of PRN medication.

10 Q. And, again, staying with the sort of analysis of 09:58 trends, either per patient or per ward, do you know after the data in relation to say the frequency of PRN usage for a patient was dealt with at MDT level, was there any formal system of that being fed upwards in terms of the chain of management at Muckamore, so they 09:58 were getting, management were getting an overall view of the frequency of use of PRN, or the frequency of use of MAPA, or seclusion, so that somebody higher up in the hospital was getting a feel for trends?

A. Yeah, I think that information was included in the 09:59 monthly report provided by H777, and then that information would have been shared with the, the senior management of the hospital, and the governance leads for the hospital.

11 Q. If we could then move on to staffing issues, and we're looking at paragraph 93, please?

A. Mhm-mhm.

12 Q. And here you say that when you were a charge nurse you ensured you had sufficient staff cover for a shift and you requested further staff from the nursing office and developed plans for the day to mitigate any shortfall, and the Inquiry has heard a lot of evidence in relation to staffing issues at Muckamore? 09:59

A. Mhm-mhm. 10:00

13 Q. Thinking back to that time as a charge nurse and throughout your time at Muckamore, was that something that happened often that you were having to arrange further cover or that there was a shortfall?

A. Yeah, I think that was a daily occurrence. I can't recall a time when there wasn't a need for somebody to have some level of cover or additional support. 10:00

14 Q. And you say that you would have developed plans to mitigate the shortfall. Can you tell us a bit more what that looked like? 10:00

A. Yeah. Well I mean I suppose ultimately them plans involved a reduction in some other part of the service for the day. That might have been an impact upon what staff activities were going to be in terms of maybe not attending a meeting, or not attending a training course, or it may have impacted upon the patient's plans for the day in that maybe it didn't involve attending an outing, or on a very worse case scenario, maybe not being able to attend an appointment that had 10:00

been planned.

CHAIRPERSON: Were there any periods where the staffing issues were particularly acute?

A. Yeah, I suppose following 2017.

CHAIRPERSON: When the suspensions started. 10:01

A. And then 2018, when the suspensions started.

CHAIRPERSON: Yes.

A. December 2018 was probably the worst that I can remember. There was a high number of suspensions, quite a lot of staff had left, a lot of staff had 10:01 reported unfit for duty and were unwell, so -- and then against that and the backdrop of trying to maintain safe staffing, I think that was the period when ICU closed in and around, I think it was in and around Christmas Eve of December '18, and that was probably 10:01 the most challenging staffing I had experienced in the hospital.

15 Q. MS. BERGIN: You've described specific examples of a meeting, staff not being able to go to a meeting, for example, or a patient trip not going ahead. In your 10:02 experience, were there ever times when that staffing deficit meant that you felt you couldn't - not you personally, but the ward - couldn't provide safe care to patients?

A. I think we always took steps to make sure that it was 10:02 as safe as possible with what we had. There would have been occasions when you might have had patients who had been required to have maybe a one-to-one, and you might have been having to share that resource with another

patient, who maybe didn't have a high level of support needs and didn't need one-to-one, but needed somebody to be able to be in the area and to be there if they needed something. So you were using staff who were on essentially one-to-one supports to provide also cover for other patients in the ward.

16 Q. Okay. If we could then look at paragraph 96, please, and we're moving on then to psychology input at Muckamore?

A. Mhm-mhm. 10:03

17 Q. And here you say that:

"Donegore Ward was unique as it was jointly led by consultants in psychiatry and psychology. We had more psychology input than any ward. We had behavioural 10:03 nurse input."

And at paragraph 102 you also refer to this, and you say:

10:03

"In terms of ward culture, Donegore Ward was the first ward in Muckamore I worked in where thinking about Positive Behaviour Support as a core ethos started to develop."

10:03

Given what you say about the involvement of psychology on Donegore, do you think Muckamore had enough psychologists?

A. No, I don't. I don't. I seen the benefit of having

the psychology input in Donegore. It was a different lens, I suppose, through which things were viewed. It was a very challenging ward to begin with and it had just opened. So our consultant psychologist had a different lens in which to view things and look to make practice less restrictive, and thought about ways of, I suppose the messaging and the language that was used, and how to support staff as well. So I think there was a real benefit to it. 10:04

I also -- it's taken me a lot of time to recall this -- but we did also have a psychologist working in the ward who would have undertaken one-to-one work with some of the patients as well, and I hadn't seen that in other wards up until that point. 10:05

18 Q. Okay. If we could then move to paragraph 125, please, and we're moving on to audit and governance, and here you say:

"The hospital also had an audit and inspection programme which was peer based and managed by non-ward staff aligned to the governance team. This was called "Ensuring Quality Care" (EQC) and provided inspections of all wards and departments and development of improvement action plans." 10:05

Were these EQC inspections occurring from when you started at Muckamore, or when were these introduced?

A. I can't remember when exactly it started. I definitely

remember them in Donegore. I wasn't in Fintona long enough, because I suppose Fintona was, it was essentially four months, it was closing of Fintona and opening of Donegore. I think they were operational when I was in Moylena, but I can't be certain. 10:06

19 Q. And can you tell us a bit about these inspections? How frequent were they? Who carried them out? What were they looking at in terms of topics? Was it safeguarding or environment on the ward, or what was the focus of them? 10:06

A. I think a lot of the focus was in relation to the care plans and the care records, and there was also a focus on the environment. I can't recall if there was a focus on safeguarding. They would have been undertaken, I suppose it was within the remit of the 10:07 governance team, and would have been led, I think, or coordinated at least by H777, and there would have been staff from across the hospital who were part of that, I suppose that group, and then they would have undertaken the audits in wards and departments that weren't their 10:07 own. It would have looked at whether, I suppose the standards in terms of the care plans were being met in terms of NMC standards for record keeping if there was signatures, if it was written correctly, if it was dated. I can't recall with accuracy what other fields 10:07 there were in it.

20 Q. In terms of how rigorous these were, thinking back to that time, was it your impression that these were an effective form of governance? Did they produce any

changes or challenge with staff?

A. Yeah, I think they were informative, and I think it led to improvements in terms of the record keeping. I'm not sure they would be overly rigorous, and I can't recall what the follow-up process was in terms of the action plan, and I certainly wouldn't have had the same rigour as an RQIA inspection. So I think it was more about informing teams and providing, I suppose, some feedback. 10:08

21 Q. You've talked really more of what seems to be, without putting words in your mouth, a process based. Were these more process based to ensure that procedures were being followed, or were they actually looking substantively at the care plans being implemented? 10:08

A. Yeah, I think it was more process based. I don't think it was sort of voluntary to see if the care plans were being implemented. 10:09

22 Q. Okay. Then if we move to the following paragraph, 126, please? Here you say:

"Ward managers would also have completed self-assessments quarterly using the Service Improvement Accountability Framework (SIAF) which was developed by the nurse development leads in central nursing alongside the Trust governance team. These were reported to the senior managers and to the Executive Director of Nursing via the Assistant Directors of Nursing." 10:09 10:09

Can you tell us a bit more about the Service Improvement Accountability Framework assessments?

A. Yeah. And, again, I suppose they were, they were self-assessments by the charge nurses of each ward. They were Trust-wide. So it was the same tool used across the Trust, and there were fields in it that maybe weren't relevant to our service. The one that wasn't relevant would be nurse facilitated discharge, so that would have been left blank. There would have been a section on it to record whether mandatory training, for example, was up-to-date, whether people had had supervision, whether -- I think it was more sort of the management function of nursing, attendance management processes had been followed. Again, there was a range of fields. I can't recall what they all were. 10:09 10:10 10:10

23 Q. But both of these -- well the first type that we've talked about in terms of audit or governance were the Ensuring Quality Care peer assessments that we've discussed, and then we've now moved onto the self-assessments. In terms of other more rigorous internal management assessments or audits, throughout your time at Muckamore, was there anything else that you had to engage with, or that you carried out, that was more rigorous in terms of looking at the care being provided to patients and challenging staff in relation to that? 10:10 10:11

A. I'm trying to think of the tools that we used. There was the monthly monitoring tool that sort of 8As would

have used to monitor performance within the wards, and there was a finance audit tool as well. In terms of actually monitoring the delivery of care, I can't recall if there is a specific tool for that, that would have been completed by somebody externally to the ward. I think usually the responsibility for monitoring whether care was effective sat with the clinical teams of each ward.

If I think -- I just want to go back to the EQC one, and I suppose part of the EQC inspection, I think there was part of that looked at if there was an assessed need for somebody, was there a care plan for it. But in terms of actually monitoring the, following the process through and triangulating that information, I don't think there was anything within the hospital that did that, other than I suppose a clinical team reviewing the care of the patients within their care. I think RQIA was the first time I recall somebody actually following the journey through, reviewing the progress notes, reviewing the Datix notes, and triangulating all of that information to see if it had been followed correctly.

DR. MAXWELL: Can I ask, the sort of audits you've talked about are largely administrative.

A. Mhm-mhm.

DR. MAXWELL: Was there a clinical audit function that looked at clinical outcomes?

A. I can't recall one.

DR. MAXWELL: Okay. And, secondly, the Royal College of Psychiatrists has, for a long time, had standards for in-patient learning disability units. Were you aware of those standards being used to evaluate MAH?

A. I'm aware that there was the quality network. 10:13

DR. MAXWELL: Yes. Which is part of that, yes.

A. Which is part of that. And there was a couple of wards went for accreditation through the quality network.

DR. MAXWELL: So they would have been evaluated as part of the accreditation process. 10:13

A. They would have been -- yes. But that would have been, I think that was probably in and around 2014/2015, and I'm not sure if there was anywhere using those standards prior to that.

DR. MAXWELL: Okay. So you think those standards were 10:13 being used to evaluate care from about 2014?

A. I think that's the earliest I recall the quality network within the hospital.

DR. MAXWELL: Thank you.

24 Q. MS. BERGIN: If we could move on then to paragraph 133, 10:13 and I want to ask you now about injuries to staff.

A. Mhm-mhm.

25 Q. And here you say:

"The staff in Muckamore had an unreasonably high 10:14 threshold when it came to personal injuries they sustained daily, which in many other services would have resulted in placement breakdown. Many staff received life-altering injuries and trauma during their

careers and continued to care for patients when other services could not."

And at paragraph 26, and we don't necessarily need to go to it, but here you say that: 10:14

"Some staff were not provided with immediate post-incident support when assaulted, due to staffing being at a bear minimum, which resulted in a traumatised workforce who perhaps overreacted in 10:14 situations due to their own fears and anxieties."

Do you think that such a tolerance of, what you've described in terms of behaviour towards staff, may have made retaliatory abuse by staff more likely? 10:14

A. I don't think, I don't think I would say retaliatory abuse more likely. I think I, as I mentioned, there's the potential for overreaction, and by overreaction I mean, overreaction to perceive a situation worse than it possibly may be, I suppose based on prior experience 10:15 where somebody has been hurt in the past, and they may see something starting to begin, but nothing had actually happened. So I think people might have perceived, or could have perceived a situation as being worse and causing them to react sooner. 10:15

CHAIRPERSON: Does it follow there may be a failure to use de-escalation appropriately?

A. Yeah. Yeah.

26 Q. MS. BERGIN: How do you think injuries to staff could

have been better dealt with then in terms of addressing these issues?

A. I suppose for me to look, or I look and think about injuries to staff, there probably wasn't enough support for staff, and I was thinking along the lines of things being very processed, processed orientated. So when de-briefs were introduced it was about identifying learning. The process would have been doing occupational health referral, if somebody was -- and it kind of feels, looking back, it's a bit tick-boxy, and certainly some -- in more recent experience I think there's probably a need for more psychological support and emotional support for staff about diffusing situations for them, as opposed to de-briefing situations straight away. I think it was clear for me that there wasn't enough staff to enable people to feel supported. So you were -- if staff got injured, I think the best that they got maybe was, you know, some time away from the working environment for a cup of tea, or to have a cry, to have a chat with somebody. But unless they were sufficiently injured, and that sounds awful to say it like that, but unless they weren't injured enough that they went off duty, then they were expected nearly to go back in, and I think they had that expectation of themselves, that they went back in and still worked with somebody, despite being physically hurt and suffering some level of upset.

DR. MAXWELL: Can I ask, if a patient is injured in an interaction with a member of staff, there is an

investigation and a protection plan put in place.
A. Mhm-mhm.
DR. MAXWELL: If a member of staff is injured during an interaction with a patient, was there any investigation at all about how it occurred and how staff could be protected? 10:18
A. Certainly, I mean we, we did have a de-brief model, and again -- we had two de-brief models that we had available, which was through the MAPA training programme. But the coping model, as I said, it seemed a bit "processy", and it was more process, and it seemed a bit impersonal for the staff that had been injured. But it did involve looking at patterns to behaviour and investigating if there was alternatives and ways we could respond to it. 10:18
DR. MAXWELL: So did it look at the ways to prevent future injuries?
A. Yeah, it did.
DR. MAXWELL: And what sort of things would be put in place to prevent future injuries to staff? 10:19
A. I suppose when I look back at some of the -- it depends what people had found in through that de-brief process, if there was things that were apparent that they could change. Certainly in my current role in the environment we work in, we have purchased protective clothing for staff to help protect them from bites and scratches, that they would have been able to wear in work. There was also making sure staff had enough assistance in terms of alarms and things like that. 10:19

But in terms of, in terms of preventing injuries to staff, I think the focus needed to be more in preventing the incidents from occurring.

DR. MAXWELL: Well, yes, exactly, that's what I'm thinking. 10:20

A. Yeah.

DR. MAXWELL: So, you know, it would seem to me that if a member of staff who was injured, it might indicate distress and unwellness in the patient, because I shouldn't imagine it was often intentional. And so was 10:20 that an indication that the treatment plan, or the environment in which the patient was being cared for, was not in, not working for that patient?

A. Yeah.

DR. MAXWELL: Did this trigger an MDT review about 10:20 'This patient is clearly becoming more distressed because'...

A. Absolutely.

DR. MAXWELL: ... 'they're injuring staff', and the point you did mention about, are there enough staff to 10:20 make sure that this patient is allowed to do activities, is given the opportunity to self-regulate, to what extent was that discussed and documented after an injury? Because after a patient injury there's quite a big and detailed consideration as part of the 10:21 safeguarding process, but it doesn't sound as though there's an equivalent of the safeguarding process when a member of staff gets injured?

A. I think if it was -- I don't think it would have

happened to the same extent for, I hate saying "minor injuries" as well, but for injuries that didn't have a more severe effect on staff. I think if staff were severely injured there was probably more of a look at them things that you're talking about.

DR. MAXWELL: But was that a formal process or was that --

A. I don't think so.

DR. MAXWELL: -- dependant on which manager was on duty on the day?

A. Yeah, I don't think it would have happened on the day at the time of the incident, and I suppose there was probably a sense -- I think possibly there was a sense that every option had been exhausted. It's right, and I've mentioned it, we had patients who were effectively stuck in hospital, in environments that in no way were suitable to meet their needs.

DR. MAXWELL: I accept that there are better ways of looking after people in hospital, and there are worse ways of looking after a person in hospital, even if you can't discharge them, surely?

A. No, absolutely, yeah. Absolutely. And I think, I think alternative approaches were tried on a lot of occasions, but the level of assaults within learning disability on staff in Muckamore alone would be more than the combined amount across probably the entire Belfast Trust.

DR. MAXWELL: So you would say that was significantly higher than in mental health settings?

A. Yeah, I would. Significantly higher.

27 Q. MS. BERGIN: If we could now move on to the second topic I told you yesterday we'd look at, which is resettlement, and at paragraph 86, please, and I'm going to summarise a few paragraphs between 86 and 92, all right? 10:23

A. Mmm.

28 Q. So between 86 and 88 you outline your role as operational manager for the resettlement project between 2014 and 2017, and you say you were dealing with placements for patients ready for discharge who were on the priority target list who had been at Muckamore since before 2006, and you were also involved in resettlement of delayed discharge patients who were medically fit for discharge but didn't have a placement or package in the community. Your role was to coordinate with Trusts and Muckamore through care assessments to enable scoping for placements and referrals according to patient needs. 10:23 10:24

You say at paragraphs 90 and 92, that you attended some family meetings about resettlement and you Chaired some stakeholder meetings, and you found resettlement to be complex, it was difficult for families and patients, some patients wanted to be resettled and so did their families, and others did not. 10:24

We're going to come and look at some specific aspects of your role in a moment, but if I can ask you about

that generally? The Belfast Trust has been criticised on a corporate level for its failure to move patients more promptly into resettlement. In your view, what were the main factors working on the ground in resettlement which prevented swifter resettlement? 10:25

A. I think the main issue was a lack of appropriate placements, a lack of suitable accommodation, and a lack of community services. There simply weren't the places. I think during my years in the role there were a lot of projects that were in development to provide 10:25 accommodation for people to move out of the hospital. So it would indicate that there wasn't enough to begin with if they were still being developed when I came into post. I think the project had been going for a number of years prior to that. So, yeah, there wasn't 10:25 enough accommodation, services, or providers.

29 Q. If we can look then at the successes or challenges then of resettlement itself when it was taking place, and if we look at paragraph 111, please? And here you say:

10:26

"I think all the resettlements were challenging for a variety of reasons, including the length of time people had been in Muckamore and supporting people outside a hospital environment."

10:26

You say:

"It was great to see people living in their own apartments, but it was a challenge for some patients

leaving the support and the community sense they had in Muckamore."

Further on you then go on to say that:

10:26

Resettlement for some patients was challenging because after a few months some patients missed being in a hospital were there were lots of people who they could speak to and see."

10:26

And you say:

"The patients had a period of excitement following resettlement but then that wore off. Some patients may have been re-admitted or at least more supports needed 10:27
in the community. I recall one patient who was excited about their own house and having Sky television and going into town. After two or three months of television and going for coffee on his own, he became lonely and wanted to come back to Muckamore. I think 10:27
some patients started to experience a sense of loneliness compared to what they had received in Muckamore."

And at paragraph 112 you say that: 10:27

"There is a different threshold for tolerating challenging behaviours in some community services. When the behaviours increase in a community setting,

this can lead to a placement breakdown and detention or admission to Muckamore. In Muckamore there is no option other than dealing with it. Muckamore was the backstop when there were failures in other parts of the system. When a patient was in Muckamore, there was nowhere else to go, but when there was a community setting, a patient could be removed."

Now, the Inquiry has heard evidence about unsuccessful resettlements. Did you have experience of these? 10:28

A. Yes, I think not every person who was, who left the hospital, had a successful first attempt at discharge, and some people returned. I think the vast majority of anybody who returned, that I recall, was during a period of trial resettlement, and I think that's -- 10:28
that was the purpose of trial resettlement. So there was detailed planning, it was done at the pace of the patient, but there is also an element of unknown with any discharge, and it's not possible to always predict fully how the person is going to respond upon 10:29
discharge. So we would have seen, I suppose with that example, that after a while the life that the gentleman had anticipated that he wanted, there was elements of it that weren't working for him, and I suppose we found bits and pieces like that. It's not so much that 10:29
people maybe wanted the hospital, I think it was the relationships and the feeling of security that they missed. So I think sometimes if you feel -- I get the impression that if they feel unsafe, or they felt a

little bit in crisis, they would want something that's familiar, and that familiarity I think came from Muckamore.

30 Q. In terms of the work that was done at Muckamore to prepare patients for resettlement, do you think the risk of loneliness was something that was factored in to preparing these patients for life outside the hospital? 10:30

A. I think there was extensive assessments completed on each patient. The process would have began for a lot of the patients with the completion of an "All About Me" document, that contained the information about the person, and what they wanted, and what they considered, and that included I think involvement from families as well in that. I suppose it's difficult, difficult to assess how somebody, the loneliness, because people -- I don't think we discharged people out to sort of, to services where there wasn't plans in place for them to have activities. I think just sometimes the gloss wore off after a few months, particularly for patients who didn't have -- and this was around the time of I think there was a shift in what people anticipated day opportunities would be like, and it was a shift to move away from the day centres and have a more community based activity or lifestyle plan that would have been facilitated by the support staff and their providers. Patients would have, some patients, and it's difficult to talk about a whole -- we're talking about a range of patients here, but certainly some examples of people, 10:30 10:31 10:31 10:31

they would have attended discos in Belfast City Centre and went for coffee. But, again, after a few months of that, it's having somewhere to go to on a day and daily basis where you're doing something purposeful and meaningful, and I don't think that part of it was always right. 10:32

31 Q. You've said that in your experience, I presume you're talking about the time period from 2014 to 2017 when you were the operational manager for resettlement, and you've said that in your experience the main timeframe for resettlements failing was that initial trial period rather than after that. What were the main reasons that you came across why these placements weren't working out in the community, apart from the loneliness, in terms of maybe perhaps higher ability patients? 10:32 10:33

A. Yes. Well I think also sometimes the behaviours were challenging for providers and they maybe didn't, didn't have a feel that they were able to continue to manage and support the people who had moved out to them, and I suppose that was sometimes a wee bit about, where I talk about the threshold as well, in that sometimes what would have happened, staff would have got injured and left, just left their post, and made it more challenging then. So you could have, you could have done an extensive period of in-reach work with staff who then would have got injured and left, and then as new people came into post they didn't have that period. So it was nearly as if it was a gradual decline in the 10:33 10:33

robustness of the supports available to the person.

32 Q. Okay. So you've really described there then the loneliness, and also the patient experience in terms of moving out to the community and not having the same level or intensity of day care services? 10:34

A. Mhm-mhm.

33 Q. And then also staffing issues. Was there anything else in your experience that was the key catalyst for patients having to return to Muckamore? There may not be, but... 10:34

A. I can't think of anything, anything else.

34 Q. And was there any type of -- we've talked about Datix and various points of analysis in your time at Muckamore, was there any type of, I'm just thinking to your role at that time as a manager, analysis, and then 10:34 I then I suppose was it dynamic, were you acting on feedback? So if you were aware a placement had broken down in one place due to a particular issue, was that then fed back, and did that then I suppose inform future resettlements with that location or patients of 10:35 that type?

A. No, there wouldn't have been a sort of thematic analysis across it. It was looked at very much on an individual basis, and I think it was a relatively small sample of people who did return. The vast majority of 10:35 patients who were resettled, were resettled successfully, from my recollection. And I think there was, at some level there was an understanding, and that was built into the process, that it was a reassurance I

think for patients that they could return during the period of trial resettlement, if they went out and they didn't like it and it wasn't working for them, they could return and we could look at it again and look if there was something else that they would feel they're better suited to.

35 Q. If we could look at paragraph 110 then, please? And here you describe in some further detail some aspects of your role as operations manager for resettlement, and you say: 10:35 10:36

"Care managers from each Trust supplied information and I collated this and prepared a master sheet for the hospital. This was discussed within Muckamore at the resettlement meeting. The data included information on..." 10:36

- and you say various aspects of resettlement, including whether a patient was part of a priority target group, and then information about the expected date of discharge, information about the plan for discharge, and other key information at (h), was that: 10:36

"Information was provided in relation to forecasted delays and high cost packages." 10:36

And you say:

"There was an initial plan of £84,000 allocated for

each person's package. Most packages exceeded that. I was involved in the analysis with the care managers to assess whether the package was adequate for the patient's needs and that the costings were accurate and value for money." 10:37

Now you say this figure of £84,000, most packages exceeded that, would some packages have been less than that or was that generally the bare minimum?

A. I don't think I -- by the time I had come into the post, I don't think there were too many people left to be discharged who didn't have some level of additional need. I think the £84,000, I suppose is a figure that was at the onset of the project being commissioned, and I suppose there was probably some sort of financial 10:37 10:38 reason for having that figure based upon forward planning and budget planning. I'm not entirely sure. There were people who would have been discharged, in the years to me prior to being in post, who went to nursing home care, and that would have been less than 10:38 84,000. I think the standard nursing home package at the time was probably in and around about 40,000.

36 Q. And are we talking around 2014-2017, is that, or do you mean prior to that?

A. Oh, that would have been like 2012, 2011. 10:38

37 Q. Yes. Prior to that period.

A. So that sort of predates me being in post, but obviously I sought some information in relation to the post.

38 Q. So those figures hadn't really changed in terms of that base level by the time you were in post in 2014?

A. No.

39 Q. Yes.

A. Yes. So... 10:38

40 Q. And when you say that they generally exceeded that amount, without giving perhaps the specific figure, I mean are we talking a significant excess of that, or was it in or around those figures?

A. The vast majority of packages I recall were six figures. We're probably talking about 150,000 as an approximate figure. Again, it could have been slightly more or slightly less. 10:39

41 Q. And you've indicated that these were patients who perhaps were more complex or higher needs patients that we're talking about, is that correct? 10:39

A. That's correct, yeah. So maybe needed one-to-one support, or maybe just needed a more intensive nursing support service where it was smaller numbers, maybe six people in the nursing home. 10:39

CHAIRPERSON: Is that the initial planned value or is that the annual cost you're talking about?

A. That was the annual. That was the annual revenue of the placement.

MS. BERGIN: I have no further questions for you in relation to this section of the evidence before we move to the restricted, but the Panel may? 10:39

CHAIRPERSON: No, I think we've asked them as we've gone along. So we can move then to the restricted part

of the evidence, which I think is just two paragraphs isn't it?

MS. BERGIN: Yes. Yes, that's correct.

CHAIRPERSON: Can we turn off the feed to Room B, please, and can we have a separate transcript. 10:40

RESTRICTED SESSION

OPEN SESSION RESUMED

10:40

CHAIRPERSON: Thank you for coming back. I am glad that we didn't try and finish yesterday afternoon. H189, can I thank you very much for giving some very thoughtful evidence, and I can now let you go with Stephen, who will look after you. 10:46

The next witness is considerably shorter, but nevertheless we ought to take a break. Now would be a convenient time. So we'll take 15 minutes now and then have the last witness. Thank you. 10:46

SHORT ADJOURNMENT

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS: 10:54

CHAIRPERSON: Ms. Briggs.

MS. BRIGGS: Good morning, Panel. The final witness before the break is H885, who is a retired nursing

assistant from Muckamore. The statement reference is STM-241. The witnesses is to be referred to by her cipher, and there are no other complications, Panel, and the witness can be called, unless there is anything further.

11:03

CHAIRPERSON: No, let's get the witness in. Thank you. The cipher is?

MS. BRIGGS: H885.

CHAIRPERSON: Thanks

11:03

H885, HAVING BEEN SWORN, WAS EXAMINED BY MS. BRIGGS AS FOLLOWS:

CHAIRPERSON: I'm going to refer to you as H885. Can I welcome you to the Inquiry. Thanks for your statement and thanks for giving up your time this morning to come and talk to us. In general terms, as you've been told, we'll refer to all staff by a cipher, and yourself by the cipher. If you make a mistake and name somebody, don't worry, all right, we have systems that can deal with that, and it'll just mean that we'll pause for a few seconds. All right? Okay. Ms. Briggs.

11:04

11:04

42 Q. MS. BRIGGS: Thank you, Chair. H885, good morning. We've met earlier on. I've explained to you about the ciphers, as the Chair just has as well. Okay. So try to use those, and if you forget don't worry, we'll deal with it, as the Chair has explained to you. Please speak as slowly and as clearly as you can. There's a microphone there in front of you. Okay. The first

11:04

question is a very easy one, you made a statement for the Inquiry, isn't that right?

A. That's right, yes.

43 Q. And it runs to 12 pages. Do you wish to adopt the contents of that statement as the basis of your evidence to the Inquiry? 11:05

A. Yes.

44 Q. Okay. And to summarise your roles within Muckamore, is it correct to say that you worked in Muckamore very briefly in 1970 as a nursing assistant, and then you worked as a Band 3 nursing assistant from 1997 until you retired in 2020? 11:05

A. That's right.

45 Q. What sort of training did you have when you started in Muckamore in 1997? 11:05

A. Within Muckamore? Training within Muckamore?

46 Q. Yes.

A. I didn't have any training whenever I went into Muckamore in '97 within Muckamore. I did have training outside Muckamore before I went there to work. 11:05

47 Q. And was that in relation to previous work that you had done elsewhere?

A. Yes.

48 Q. But not in relation to Muckamore?

A. Yes. 11:06

49 Q. And what training was that?

A. I had a residential home of 40 residents that I ran, I was manager of.

50 Q. Okay.

DR. MAXWELL: You were the registered manager of the care home, were you?

A. Yes.

51 Q. MS. BRIGGS: All right. And presumably then you obtained training in Muckamore as time went on through the years from 1997 through to 2020? 11:06

A. Yes.

52 Q. Okay. I'm going to ask you about that in due course, all right, we'll come to that.

You go on in your statement to describe the various wards that you worked on from 1997 until 2020, and I'm just going to summarise that. Okay? You worked in Movilla B, M7B, you were there for 18 months? 11:06

A. Yes.

53 Q. You then went to Movilla A, M7A, for a short period. 11:06

A. Yes.

54 Q. And that was six weeks. Then you went to F7 North for six years?

A. Yeah.

55 Q. And then you went to Foybeg F2 Ward for five years, and then you went to Six Mile in 2010. Is that right? 11:07

A. That's correct, yes.

56 Q. And you finished your career in 2020 in Six Mile?

A. Yes.

57 Q. Okay. And when you were working across all of those wards, how often would you say that you were working alongside a registered nurse? 11:07

A. Always.

58 Q. And what about when you were providing direct patient

care, was there always a registered nurse there with you?

A. No.

59 Q. Okay. Can you tell us a little bit about that?

A. It would have been on a one-to-one with a patient and, therefore, I would have been taking them out to day care, or taking them out for a walk, or something like that. So I would have been on my own with them then. 11:07

60 Q. So when you were taking the patient places you might have been by yourself? 11:07

A. Yes.

61 Q. What about when you were providing say care, personal care and hygiene, was there a registered nurse there at those times?

A. No. 11:07

62 Q. Okay.

A. No.

63 Q. I'm going to ask you about one or two of the wards that you worked on in particular. Okay. M7A Ward, okay, you describe that at page 2, paragraph 5? 11:08

A. Yes.

64 Q. You say at that paragraph that you worked there in February 1999 for about six weeks?

A. Yes.

65 Q. And you describe it to be known as a "male lockup"? 11:08

A. Yes.

66 Q. What do you mean by that?

A. It was a lockup ward. It was locked continually. The ward was locked. You had to have a passkey to get into

it. You had to have a key to get out. There was a seclusion room in it, and it was mainly male staff that were in it. And it was just -- and that's what they called it, the male lockup.

67 Q. And it was a lockup ward because the particular patients that were there? 11:08

A. Yes. Yes.

68 Q. Okay. What sort of training were you given when you worked there, and this was at the very start of your long period at Muckamore, what sort of training were you given when you went there regarding restrictive practices and the like? 11:08

A. We would have went to MAPA training. That would have been the basis of our training really.

69 Q. When did you first get MAPA training? 11:09

A. About maybe 1998, and then it was continued every year, you had an update every year.

70 Q. And what about other training other than MAPA? Was there training in say managing challenging behaviours?

A. Yes. 11:09

71 Q. Positive behaviour support?

A. No, managing challenging behaviour would have been one that we would have had updates on, but...

72 Q. And what would that training have involved?

A. Well they would have explained to you about the MAPA, but they also would have talked about de-escalating, which I was always a great believer in, that you could de-escalate any situation if you wanted to, you know. 11:09

73 Q. And thinking back now, can you recall any other types

of training that we haven't mentioned there that you got while you were at Muckamore?

A. Well, we would have done basic first aid and lifesaving, that sort of thing. We would have done those trainings, but... 11:10

74 Q. And do you feel that the training that you got at Muckamore was sufficient?

A. No.

75 Q. Why do you say that?

A. Because there was a lot of things that you didn't know about and you weren't trained for it for patient's behaviour, problems that they had. We were just coming in and -- we weren't used to that kind of behaviour, you know. 11:10

76 Q. Can you give an example? 11:10

A. Patients wouldn't have thought twice about just jumping up and trailing the hair off you. So. Or throwing something at you, or coming over and biting you, you know. We weren't really trained in any way to know that when the patient was going to do that, or we weren't really involved with it, you just were there and if they done that, they done it. 11:11

77 Q. And was the challenging behaviour training you got, it wasn't enough?

A. It wasn't enough, no. 11:11

78 Q. Right.

A. The -- sorry.

DR. MAXWELL: No, if you wanted to say some more, say some more.

A. I was just going to say that, you know, the training was for when a patient attacked you, it wasn't for when -- if the patient was going to attack you, how do you stop it without putting hands on or anything. You know, we needed more training in that as to how we could have diffused situations rather than putting hands on patients.

79 Q. MS. BRIGGS: I think Dr. Maxwell has a question.
DR. MAXWELL: I want to ask you about some other sort of things that you might have had training in. So I think quite a few of the patients had epilepsy.

A. Yes.
DR. MAXWELL: Did you get any training in epilepsy?

A. No, I had training in epilepsy, but not in Muckamore.
DR. MAXWELL: Okay. Other conditions. So I presume some of the patients would have had diabetes?

A. Yeah, but no training. Again I had training in looking after diabetics, but not within Muckamore, I didn't get the training.
DR. MAXWELL: So some of the other nursing assistants or healthcare assistants who hadn't had previous work, they were working with these patients without --

A. Without training.
DR. MAXWELL: -- without knowing about these conditions?

A. Yeah.
CHAIRPERSON: And when you say that you would have liked more training to prevent you having to put your hands on a patient, as it were.

A. Yeah.

CHAIRPERSON: You did have -- if you had done some MAPA training.

A. Yes, we had MAPA training.

CHAIRPERSON: So you would have learnt a bit about de-escalation? 11:12

A. Yeah, but a lot of the MAPA training was really about putting hands on, you know.

CHAIRPERSON: Okay.

PROFESSOR MURPHY: I think what you're saying is that you didn't have any training in Positive Behaviour Support, is that right? 11:13

A. That's right, yes.

PROFESSOR MURPHY: Even though that was part of most patient's care plans? 11:13

A. Yes. Yes.

80 Q. MS. BRIGGS: Okay. H885, I want to move then to the end of your career where you finished up, which is on Six Mile. Okay?

A. Yes. 11:13

81 Q. And you worked there 2010 until 2020. This is at paragraph 7 on page 3. Towards the end of that paragraph you say that there were a lot of staffing issues on Six Mile due to multiple staff leaving. When was it that staff were leaving? Was that in 2010 or was that later on? 11:13

A. It was later on. It was in 2018, I think it was, in or around that, when problems started to come into the hospital, staff were leaving. Younger, younger staff

came into Six Mile. It was sort of -- at the beginning Six Mile wasn't to employ younger female staff, but then they decided that they were bringing in young female staff, and they really had a whole different outlook to how the place was being run, and they just created a lot of problems and a lot of atmosphere within the ward.

82 Q. When they brought in young female staff as you say?

A. Yeah. Yeah.

83 Q. Was that out of necessity because of staff leaving? 11:14

A. Well, I don't really know why, you know, why they brought in young female staff into a ward where it was male staff that were there, all with different complex needs.

84 Q. And thinking in particular about staff leaving and the changing of staff on the ward, how did that affect the care to patients on the ward? 11:15

A. Well, I mean they still got, they still got care. They still got care. There were still staff coming in and giving them care, but they just -- the men on that ward just did not respond to the young female staff the way they should, and it created problems. 11:15

85 Q. What do you mean by that?

A. Well I mean the patients on Six Mile were all offenders, and a lot of the offences was against young girls, so I mean you can just see how that would create problems in a situation like that. 11:15

DR. MAXWELL: Are you saying that the patients were behaving inappropriately with the young female staff?

A. Yes. Yes.

86 Q. MS. BRIGGS: You mentioned something else about Six Mile in your statement, this is at page 4, paragraph 10. You say there in the first sentence that the culture on the wards varied across Muckamore, but there would have been certain days on Six Mile that you knew patients were going to play up because certain staff would have been working. 11:16

A. Yeah.

87 Q. Can you tell us a little bit more about that? 11:16

A. Well that would be sort of with the young female staff. If you had a young female coming in and being there and you had a couple of male staff that were just being inappropriate and it just always then escalated out of control. 11:16

88 Q. And did those working at a more senior level, say the Ward Manager, were they aware of that?

A. Yes.

89 Q. What did they do about it?

A. Nothing. 11:17

90 Q. Did you report your concerns about that to anyone?

A. I said it a few times, yes.

91 Q. And what was the response?

A. "Get on with it."

92 Q. Can you remember, without using names, who you said that to? And you can say "Ward Manager", or you can say "line manager", but if the name is there, let us know? 11:17

A. H13, H14, and H77.

93 Q. Okay.
A. I mentioned it to those three people.
94 Q. And their response, it wasn't helpful?
A. No.
95 Q. You describe, H885, in your statement, going to other wards like Greenan or Donegore when they needed assistance or were low on staff? 11:17
A. Yeah.
96 Q. This is at the bottom of page 4 on paragraph 11?
A. Yeah. 11:18
97 Q. You say there how the atmosphere and culture on the other wards was not always great, as staff there did not want you there. Were some wards more hostile to relief staff than other wards?
A. Yes. 11:18
98 Q. Which wards were more hostile, would you say?
A. Well, I would say that Greenan and Donegore would have been. They didn't want you there because -- well, they had their own system, and a stranger coming in not knowing what they were doing maybe upset things, and they just didn't make you very welcome. 11:18
99 Q. Okay. Now the Inquiry has heard some evidence that Greenan and Donegore, the atmosphere was good and the team were supportive, you would disagree with that then? 11:18
A. Yeah.
100 Q. Was it perhaps that there were cliques or groups of staff that were already there and bonded?
A. Yes.

101 Q. That made it difficult to feel part of the team?
A. Yes. Yes.
102 Q. And was that the primary difficulty really?
A. Yes, I think so. Yeah.
103 Q. Okay. Right. I want to pick up on a trend that you describe in your statement, okay, and that is families working together in Muckamore? 11:19
A. Yes.
104 Q. All right. And you tell the Inquiry very early on in your statement that your daughter also worked in Muckamore as a nursing assistant? 11:19
A. Yes.
105 Q. Did she work with you on the same ward at any time in your career?
A. No. 11:19
106 Q. She was always on a different ward?
A. Yes.
107 Q. Okay. And if we can go to paragraph 8, it's at the bottom of page 3. I'm going to read in what you say there. You say - and it's on the screen as well if you want to follow along that way, whichever is easiest for you. Okay. You say: 11:19

"I recall that when banking shifts became available on Six Mile my daughter was not allowed to work with me because mother and daughter were not allowed to work on the same ward. But if the staff logs were to be reviewed from that time..." 11:19

- and this is 2010 onwards:

"...they would show there were family working together permanently as well as on other wards and banking shifts."

And you go on to give examples in that paragraph of some staff who were related at Muckamore?

A. Yes.

108 Q. Were those family members working on the same wards at the same time, or were they on different wards?

A. No, they were working at the same time.

109 Q. On the same ward?

A. On the same ward, yeah.

110 Q. And you've mentioned there that mother and daughter were not allowed to work on the same wards. So how come these relatives were able to work on the same ward at the same time?

A. Well, they were management's and they were Ward Manager's family, and it was one rule for one and one rule for another.

CHAIRPERSON: Can I ask, was that exception, as it were? Did that just happen occasionally when staff needed to be called in?

A. No.

CHAIRPERSON: Or are you saying that was really the rule?

A. That was the rule. I mean if, if they needed a shift covered, they were asked first. Families were asked

first.

CHAIRPERSON: But the roster would be designed, as it were, and are you saying that it would be a regular occurrence for family members to work together on the same ward as part of the roster? 11:21

A. Yes. In Six Mile, yes. Yes.

111 Q. MS. BRIGGS: Are you aware of any problems that arose from having family members working together in that way?

A. Not -- it didn't create any problems for me. I didn't see why my daughter couldn't, if the Ward Manager's family was able to work alongside them, I didn't see it was a problem that my daughter couldn't work alongside me, but it was never allowed. It was -- if I put her name forward, whatever, it was always one of their own family members that got the shift. So... 11:21 11:21

112 Q. But might it have affected, say, reporting of concerns, if a staff member was aware that another staff member had done something that they perhaps weren't comfortable with, but they're also aware that that staff member is related to someone more senior, did it affect how concerns like that might have been reported? 11:22

A. I would say it could have done, yes. Yeah. I don't know of anything specific, but I know that you would have been up against it to go and say. So, yeah. 11:22

113 Q. Okay. But it wasn't a problem that you had directly experienced in your time?

A. No. No, no.

114 Q. Okay. I want to move on to something else now. Okay?

Another matter you describe is the types of people you were working with in Muckamore, and this is the top of page 5, paragraph 12. You say there that:

"The differences between the various wards at Muckamore usually came down to the personalities of the staff that worked on them. You had your good, friendly staff, and you also had staff who were horrible people." 11:22 11:23

A. Yes.

115 Q. And you go on in that paragraph to say that there were horrible people on every ward, is that right?

A. Yes. Well there's horrible people everywhere.

116 Q. That's right. Did you ever see those people interacting with staff in a way that demonstrated them being horrible, or interacting with patients in a way that demonstrated them being horrible? 11:23

A. I mean one of the things that they were all very good at, with the horrible people was, in your tea breaks. Everybody goes for tea breaks, you know, and they pick who they go with, and you could be left sitting. 11:23

117 Q. What about in their interactions with patients, would they have displayed those negative personality traits that perhaps you didn't like towards patients? 11:24

A. Yes. Mhm-mhm, yeah.

118 Q. How so?

A. By cutting them off sharp, and maybe the way they spoke to them, you know. While I never witnessed any

physical abuse, there was staff that spoke to patients which wasn't really acceptable in how they spoke to them.

119 Q. I'm going to come back to that issue, okay, about how staff spoke to patients, because it is something that you describe in your statement and I am going to come to that. But you've talked a little bit in your statement and you've talked this morning about staff kind of being in cliques or being in groups? 11:24

A. Yes. 11:24

120 Q. Would that have put staff members off reporting concerns? Say they were aware of another staff member in a clique or in a group, and they felt perhaps intimidated and they couldn't report concerns about patient care? 11:24

A. Yeah.

121 Q. Is that something you experienced yourself?

A. Well, as I say, I didn't see any physical abuse, but I know that people would have been reluctant to go and say, because it was your man's daughter, or your man's son, or uncle, or whatever, so they just -- people would have just turned a blind eye to it and got on with it. 11:25

122 Q. You go on, on that page, to say that the standard of care at Muckamore was very good, and you say that the majority of staff gave 100%, and that's at paragraph 14. And at paragraph 15 you say that you cannot recall examples of any physical abuse, and you've just told us that as well. You go on after that, H885, to talk 11:25

about management, okay, and the support provided by them, and at page 6, paragraph 18, you say:

"I did not feel supported in my role throughout my time at Muckamore by any senior members of staff. I felt that I was merely a nursing assistant and not up to par with the trained staff. I always felt I could not live up to the expectations and at times felt like I was not wanted on the wards. I certainly do not feel as though I ever received any support throughout my time at Muckamore." 11:26 11:26

Did you have a line manager?

A. Yes.

123 Q. What level or what band were they? 11:26

A. Well, your line manager was your Ward Manager, you know, that was your Ward Manager.

124 Q. And did you have supervisions by the Ward Manager?

A. Yes.

125 Q. What support might you have expected day-to-day in your role that you didn't receive? 11:26

A. Just in maybe making decisions. In an incident where a patient was maybe distressed about something, I would have been a great believer in making a wee cup of tea and maybe that would settle them. I mean I got reprimanded for that manys a time about, you know, 'you don't do that sort of thing', when I felt, why not? But, you know, things like that, where trained staff were telling me 'No, you can't do that, you can't make 11:27

them a cup of tea.'

126 Q. Can you recall who said that to you, without using names?

A. H14 and H13. Yeah.

CHAIRPERSON: I just want to understand, is this restricted to these incidents where you made a cup of tea for patients, or are you saying that there were wider examples? 11:27

A. There was wider examples of things that, you know, but I felt that as a carer, that's what I was, and if there was a situation that I could sort out by taking them for a walk, giving them a bath, making them a cup of tea, whatever diffused, giving them a sweet, whatever diffused the situation, I felt that was - that was my way that I felt of handling it, and I got good response from that. But sometimes the trained staff thought that you were spoiling them, you know. I don't know. 11:28 11:28

CHAIRPERSON: And is that an expression they used to you?

A. They said, you know, 'No, you can't be making a difference', was sort of how they would have put it, by giving -- say there was four people there, and it was only one person playing up, and you were taking them onboard to give them then, I was making a difference. So... 11:28 11:29

DR. MAXWELL: So their concern is that you would be doing something for one patient but not for the other three?

A. Yeah. But they weren't -- they were happy enough with

what was happening.

DR. MAXWELL: No, I understand. I understand.

127 Q. MS. BRIGGS: All right. In the last sentence at paragraph 18 you say:

11:29

"I recall always having to go looking for management if I needed to speak with them about shifts, as they were not always visible on the wards."

Who do you mean when you say "management"? Have you found that okay? 11:29

A. Whoever was on charge on that shift, you know, whoever was in charge, if you wanted to get them, you couldn't find them. You had to --

128 Q. So you struggled to find the likes of the Ward Manager, is that what you're saying? 11:29

A. Yes, or -- yes, or whoever was, you know, if it was, whoever was acting up that day for.

DR. MAXWELL: So that could have been a Band 5 if they were in charge of that shift? 11:30

A. Yes. Yes.

DR. MAXWELL: It's not necessarily the Ward Manager.

A. No, no. Whoever was being in charge, it could have been a Band 5.

DR. MAXWELL: So are you saying that the Band 5s weren't actually out doing the direct patient contact work? 11:30

A. No. No, they were usually in the office.

CHAIRPERSON: So when you told us earlier you always

had a registered nurse with you, what you mean is there's always a registered nurse on the ward?

A. On the ward, yes.

CHAIRPERSON: Yes. But necessarily walking the ward as opposed to being in the office. 11:30

A. No. No, they would have been in the office, but I mean that was, that was what you expected. That's where they always were.

129 Q. MS. BRIGGS: And was that in Six Mile or was that across all the wards you worked on in Muckamore? 11:30

A. Well, it would have been Six Mile. I spent the most time in Six Mile, so sort of this would be referring to Six Mile, you know.

130 Q. Okay. And the previous wards that you worked on, you didn't have quite the same concerns about perhaps lack of visibility of the Band 5s? 11:30

A. No. No.

131 Q. Or the more senior staff?

A. No.

132 Q. Okay. At paragraph 19, the bottom of page 6, you say: 11:31

"During my time at Muckamore I did not feel that I could speak about or report anything that I was uncomfortable with to management. There were times when I thought staff maybe did not behave as they should towards staff, usually by being quite short with them, and if I were to say anything to management I was told to just leave it. No-one wanted to talk about anything." 11:31

And you also mention earlier on in your statement at paragraph 15 that there were times when you heard staff use inappropriate language towards a patient --

A. Yes. 11:31

133 Q. -- if they were frustrated. And you've mentioned that earlier in your evidence this morning. When you saw staff members being short with patients, or perhaps using inappropriate language, did you say to the Ward Manager or anyone else that you had concerns about 11:32 that?

A. Yes, I would have said.

134 Q. And what would the response have been?

A. "Get over yourself."

135 Q. How many times can you recall raising those types of 11:32 concerns?

A. Lots of times. Lots of times to other staff members, Band 5, nurses, saying to them, you know, "so and so was talking to him", and it wasn't really said, "all right, okay." There was never -- you didn't have any 11:32 confidence. It got to the stage where there was no confidence in saying anything, so...

136 Q. And is your evidence that every time you raised an issue like this, you got a response of "don't worry about it" or "it's not important"? 11:32

A. Yes.

137 Q. Or something like that?

A. Yes. "Somebody will look at it", or "somebody will deal with it", but "That's okay, don't worry."

DR. MAXWELL: And who were these staff that were using inappropriate language? Were they healthcare assistants?

A. They would have been anything from Band 3 up to Ward Manager. 11:33

DR. MAXWELL: So the registered nurses would be using inappropriate languages as well.

A. Yeah. Yeah.

138 Q. MS. BRIGGS: Given the response that you say you received from the more senior staff, or the trained staff on the ward, and the dismissal which you say that they provided you with in relation to your concerns, do you think if you had of witnessed abuse, physical abuse, or very serious verbal abuse, do you think you would have felt able to report it to the managers? 11:33

A. I would have, yes.

139 Q. There's one particular thing you say about how patients were treated, and this is at paragraph 31, page 10. You're describing in the second half of that paragraph a patient who was a smoker? 11:34

A. Yes.

140 Q. And that patient was to get a certain number of cigarettes in a day, and you say that:

"...sometimes the staff member would tell him that he had too many and take one off him, even though he had not had the certain number he was allowed. I recall speaking with the Ward Manager, whose name I cannot recall, who told me she would sort it out, as the 11:34

patient had a programme of care in place."

Was it sorted out?

A. No, it continued. He, he had a problem that if, if I said to him you've got -- is this okay to say this like? If he said he gets nine cigarettes, and he says "I get nine cigarettes", and you came along and you said to him "No, you got eight cigarettes today", then he said "I got eight cigarettes today", and he would have said to him "How many cigarettes did you get? Did you get 12 cigarettes today?", and he said "I got 12 cigarettes", whatever they said, he said, and then they kept cigarettes from him because he told lies. 11:34 11:35

141 Q. So is your evidence that really the staff were taking advantage of the patient or bullying the patient in some way? 11:35

A. Well, they just weren't giving him his cigarettes that he was entitled to.

142 Q. Why?

A. Because they could. 11:35

143 Q. I'd like to ask you now about patient notes. If we can go back to page 7, paragraph 20. You say in that paragraph that you had access to patient notes, which were the main source of information on a patient?

A. Yeah. 11:36

144 Q. Were you able to write down your observations in the notes as well as read them?

A. No, we weren't allowed to write in care plans.

145 Q. Would it have been helpful if you could?

A. Possibly, yes.

DR. MAXWELL: So given that you were doing most of the direct care, did you have a de-brief with the Staff Nurse who then wrote the notes?

A. Yes. 11:36

DR. MAXWELL: And that happened on every shift, did it?

A. Well mostly, mostly. Depending on the individual that was there.

DR. MAXWELL: If a patient was on enhanced supervision, one-to-one or two-to-one, was there a -- were you given 11:36 a sort of checklist of things you had to report back to the Staff Nurse?

A. No, you were just put on a one-to-one and that was -- you dealt with it.

DR. MAXWELL: So what you told the Staff Nurse depended 11:37 on the healthcare assistant.

A. Yes.

DR. MAXWELL: Who might have given different degrees of feedback to the Staff Nurse.

A. Yes. Yes. 11:37

DR. MAXWELL: That wasn't standardised.

A. No.

146 Q. MS. BRIGGS: I'd like to ask you now a little bit more about MAPA and the use of restrictive practices, and this is at page 8, paragraph 25. You described your 11:37 training in MAPA and you say how MAPA included intervention techniques like talking and listening, and you've told us earlier in your evidence that you got this towards the beginning at Muckamore in the late

'90s, I think you said 1998, and you said that was refreshed annually, is that right?

A. Yeah, I think it was annually, or it could have been 18 months. I'm not sure.

147 Q. You say in that paragraph that you were clear about what restrictive practices were available and appropriate, but you say that decisions on when those restrictive practices were to be used were taken by trained staff and not nursing assistants? 11:37

A. Yeah. 11:38

148 Q. When you say trained staff, what do you mean?

A. Band 5s, upwards.

149 Q. And if you were talking to a patient and they became upset or aggressive, would it not have sometimes been necessary to use MAPA technique, without the authorisation of the Band 5s? 11:38

A. Not really, no. I always found that like when I was working with the patients I had good rapport with them, and I didn't really have a lot of aggressive behaviour. Aggressive behaviour was always when there was other people involved. 11:38

CHAIRPERSON: So if you're providing personal care to a patient, which you might be doing on a one-to-one basis.

A. Yeah. 11:39

CHAIRPERSON: You never felt the need to use a MAPA technique?

A. No. I always found that you could talk them round.

150 Q. MS. BRIGGS: You also say at paragraph 25 that a

decision to secluded had to be taken by a trained staff member. Is that right?

A. Yes.

151 Q. Were you involved in the observation of seclusion?

A. Not in Six Mile, because there was no seclusion room in Six Mile in the treatment side. There was in the assessment side. But, no. I would have been in F7 North, I would have been involved in doing checks in the seclusion when somebody had been secluded. But... 11:39

152 Q. And were you clear on how often you had to go to check? 11:39

A. Yes. Yes.

153 Q. And each time you made your check, would you have had to record that down somewhere?

A. Yes, you had to record it, yes.

154 Q. And what kind of things would you have been looking for? 11:40

A. Well just that there was no self-harming, you know, just how they were behaving, whether they were responding, if they had been given medication, or if they, you know, how they were responding as time went on. It was usually about every 10-minutes, 15-minutes that you checked on them and then wrote down what, if they were still sitting in the same position, or if they had moved, or if they were self-abusing or, you know, those were the sort of things that you looked for. 11:40 11:40

155 Q. Did you ever see anything when you were observing seclusions on F7 that caused you particular concern?

A. No.

156 Q. You say at the last sentence of that paragraph 25, that you heard through word of mouth that some nursing assistants did take it upon themselves to make the decision to use restrictive practices. How did you hear about that? 11:41

A. On the ward you heard. Even the patients would have said that a certain person that was only a Band 3 instructed them to go ahead, and it would mostly have been male staff.

157 Q. Were the ward managers aware of that happening? 11:41

A. Yeah.

158 Q. Was anything done about it?

A. No.

159 Q. Did you speak to anyone in particular about it yourself? 11:41

A. No.

160 Q. Why not?

A. Because the male staff and Band 3s were treated differently to the females. They had -- they were given more power. 11:41

CHAIRPERSON: And, again, can I just ask, is this a one-off example you're giving us or did you see that happen on a number of occasions.

A. No, it would have happened, it would have happened on the ward, because females were working with males, who were sometimes quite big hefty boys, that maybe the female staff weren't really up to taking onboard, so the male staff stepped in and done it. 11:42

DR. MAXWELL: So they would do it to protect a female

member of staff?

A. Ehm, yeah. Well, you could look at it like that, that it was to protect the female staff, or you could look at it that it was to make the female staff feel incompetent. 11:42

161 Q. MS. BRIGGS: I'm near the end of my questions, but I want to focus in on one particular incident you tell the Inquiry about, and this is at paragraph 27, page 9. You're describing one incident you recall where a restrictive practice had to be used? 11:43

A. Yeah.

162 Q. And you describe at that paragraph a patient, that patient is P215?

A. Yeah.

163 Q. Who required one-to-one supervision? 11:43

A. Yes.

164 Q. And you were supervising him?

A. Yeah.

165 Q. And you say that you had great rapport with him.

A. Yeah. 11:43

166 Q. And P215 wanted to know when his brother would be there to take him home for Christmas?

A. Yes.

167 Q. And he became agitated, and you took him to his room. And you say that H14, Deputy Charge Nurse, followed you. 11:43

A. Yeah.

168 Q. And H14 told the patient that he had rang the patient's brother to tell him that the patient had been

misbehaving, and the patient's reaction to that caused an incident which ultimately led to you being kicked in the head by the patient?

A. Yes.

169 Q. And the patient then had medication administered to him. Why did H14 say what he said to the patient? 11:44

A. I can only give you what -- why I think happened. They were short-staffed. I wasn't on the ward that day, I had a patient out all day, and I had just come back to the ward about 7:50 that night. My shift finished at 8:20, and I was in the office and I was -- because I had been out all day with a patient, I had money to sort out that we had taken, and receipts to put in, and I was doing that, and P215 didn't have a nurse with him because there was only one staff on the ward at that particular time, so he was just being on his own, but he should have had a staff with him, and he came into the office to me and said he was really -- he had actually said that he was going to cut his throat, and I said to him, 'Look, you know give me a minute until I get this money sorted and then I'll ring your brother for you', because he had no communications, no vocals, so I said, you know, 'I'll ring your brother and we'll sort it out what's happening for Christmas', which we done. Once I got that sorted I phoned his brother, said to his brother that he was upset, he couldn't understand when he was coming to take him out for Christmas, so if he would tell him what it was. So he went on the phone and his brother told him he was 11:44 11:44 11:45 11:45

coming whatever time it was he was coming to pick him up for Christmas. It was all sorted. That was okay. So I said to him, 'Right, come on down to your room now', and I took him down to his room and I thought I could leave him there, because there was no staff to look after him and I wasn't allocated to him, I was just stepping in because there was nobody else there. I took him to his room, and then the 714. 11:45

170 Q. 14, H14.

A. 14. 11:46

171 Q. Just double-check?

A. Yeah, H14 was in charge that night on the ward, and he came out and said that he had rung his brother and said that he was misbehaving, and then he just, that was it, that was enough to start the whole thing off, and he went ballistic, and then they said that they were going to do MAPA, put him on the floor, and... 11:46

172 Q. Why did H14 say that to the patient?

A. I don't know.

PROFESSOR MURPHY: Do you think it's possible that there had been events while you were out with the other patient that you weren't aware of that involved this particular patient? 11:46

A. There could have been, but I wasn't aware. But I don't know. I don't know. But I know that he was getting -- he was going to administer PRN to him, and that was as much as I thought was going to happen, that he was going to get the medication, but then he said, when he said to him about his brother, that just, you know... 11:47

173 Q. MS. BRIGGS: You say that what H14 said agitated the patient?

A. Yes.

174 Q. But is your evidence that you're not quite sure whether he intentionally agitated the patient or whether it was perhaps the patient had misbehaved? 11:47

A. Well, maybe it was because just -- there was no staff there, I think was the big problem. You know, this P215 was on a one-to-one all day, waking. He only went off a one-to-one when he was in bed sleeping. So he needed a staff all the time with him, and there wasn't always that staff there for him. 11:47

175 Q. And in terms of what happened to you, you were kicked in the head by the patient and you had to go to hospital? 11:48

A. Yeah.

176 Q. But you were back in work the next morning?

A. Yeah.

177 Q. What support did you get from the hospital after that incident? 11:48

A. None.

178 Q. Was a referral made to Occupational Health or anything like that?

A. No.

179 Q. Were you injured? 11:48

A. I had a bruise on the side of my head, it was sitting out.

180 Q. And were you offered any time off?

A. No.

181 Q. And when those types of physical incidents happened, or staff were assaulted or injured by a patient, was that always recorded as an incident?

A. I don't think this incident was recorded.

182 Q. Did anyone come to you to ask you for your version of events as to what happened... 11:48

A. No, no.

183 Q. ...that led to you being kicked?

A. No.

184 Q. Can you recall any other incidents where that type of investigation happened? 11:49

A. Not, no not with myself, no.

185 Q. Okay.

DR. MAXWELL: Did you think being injured was part of the job? 11:49

A. Yeah, you came to believe that, that, yes, it just happened.

DR. MAXWELL: So you just accepted it?

A. Yeah.

186 Q. MS. BRIGGS: There's another incident that you describe much earlier in your statement at paragraph 6 on page 2. That's where a female patient on F8 North, and you were there in 1999, early 2000s, that patient assaulted you by lifting you by your hair and swinging you around like a teddy bear? 11:49 11:49

A. Yeah.

187 Q. And those are your words. Did you get any support from Muckamore after that incident?

A. No.

188 Q. Did you take time off? You did take time off after that incident?

A. I did, yes.

189 Q. You did.

A. I took time off and then I got moved to a different ward. 11:50

190 Q. That's right.

A. And that was sort of how you -- what happened when an incident happened on a ward and you took time off, you didn't get back to that ward, you were sent somewhere else. 11:50

191 Q. Were you offered any counselling or anything like that after what happened there?

A. No.

192 Q. H885, that's all the questions that I have for you. Okay? The Panel might have some. All right? 11:50

A. Okay. Thank you.

H885 WAS THEN QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 11:50

193 Q. CHAIRPERSON: Can I just go back to the cigarettes?

A. Yes.

194 Q. CHAIRPERSON: Because I just want to see if that has any wider significance. What you're telling us really is that a member of staff would tell the patient that he had had his allotted number of cigarettes? 11:50

A. Yes.

195 Q. CHAIRPERSON: When actually the patient hadn't?

A. Yeah.

196 Q. CHAIRPERSON: And that could be regarded as bullying?

A. Yes.

197 Q. CHAIRPERSON: Was that a common occurrence or was it just one occasion one patient? 11:51

A. It was one patient, but a few staff would have treated him like that.

198 Q. CHAIRPERSON: Right. And what levels of staff? And I want you to think back and really try and be accurate, if you could be. 11:51

A. And you want...

199 Q. CHAIRPERSON: I don't want the names, but I just want to know the levels of staff that you saw actually doing that?

A. Ehm, Band 5s. 11:51

200 Q. CHAIRPERSON: So that would mean a registered?

A. Nurse, yeah. Yeah.

201 Q. CHAIRPERSON: Nurse. Any others?

A. Ehm, a Band 3.

202 Q. CHAIRPERSON: And are you talking about a specific Band 5 and a specific Band 3? 11:51

A. Yeah.

CHAIRPERSON: Okay. All right.

H885, can I thank you very much for giving us your time this morning and for coming to help the Inquiry, you're actually our last witness for this session, so can I thank you very much indeed for your attendance. 11:52

A. Not at all. Thank you.

CHAIRPERSON: Okay. If you'd like to go with the Inquiry Secretary.

MS. BRIGGS: That includes the witness phase session, Chair.

11:52

STATEMENT BY THE CHAIRPERSON

CHAIRPERSON: I've got a few concluding remarks before we break for the summer, and I want to start by thanking each and every witness who has assisted the 11:52
Inquiry so far. We, as a Panel, do understand that giving evidence before a Public Inquiry can cause anxiety, and that the preparation of statements and the subsequent attendance here is time consuming, but the foundation of evidence that is being built to underpin 11:53
our eventual report and recommendations is significant.

I also want to pay a final tribute to Geraldine O'Hagan, who did so much work to assist the families both in giving their loved ones a voice and in 11:53
assisting them to help the Inquiry. And literally in her dying days she completed that work, as far as she could, by giving evidence before us on the 15th May to assist the Panel.

11:53

We recommenced our oral sessions in February this year, and then of course, unfortunately, had to break for several months, but despite that we have made significant progress. This year we've called a further

30 staff witnesses and read another nine. We've completed the significant task of hearing the core evidence in relation to the investigation into the issues on Ennis Ward, and we've also heard about the reports of David Bingham and Professor Owen Barr from those authors, and we've made significant inroads into the evidence we need to hear in the 10 Organisational Modules. We've heard evidence on Organisational Module 1, which of course was patient advocacy and representation. We've heard Module 2, which was professional education. And Module 3, professional regulation, although we haven't forgotten the General Medical Council, from whom we have requested a further statement. 11:54 11:54

In relation to Module 4, the PSNI and their role in safeguarding, we have yet to hear that, but Module 5 and 6 have been substantial modules dealing with the important issues of inspection and resettlement respectively. 11:55

Regarding Module 5, the Inquiry is still seeking to obtain evidence about the role of the Mental Health Commission, and we will, of course, be picking up on some of the themes from those earlier modules with the witnesses who are going to be coming to give evidence later in the Organisational Modules after the break. 11:55

Now in relation to the taking of witness statements

which we have received over the past few months, a number of those from members of staff have included what I can describe as negative feedback about the process, and much of this feedback appears to have generic wording, but, nevertheless, it is fair to remark that the making of a statement can itself be stressful. However, this is an Inquiry into serious abuse of highly vulnerable patients, and it is inevitable that the staff at the hospital will be asked to make statements and be expected to comply with the process. That may cause some anxiety, but the Inquiry has done what it can to make the process of giving evidence as easy as possible. 11:56 11:56

I have had requests from Phoenix Law, on behalf of their clients, to hear further evidence on how resettlement has been undertaken and how it is affected their clients. Now, as we are all aware, the patient experience phase of the Inquiry closed in October of 2023, and it is not proposed to reopen that phase of the Inquiry. It must be recognised that the formal evidence part of the Inquiry has boundaries and is limited to a large extent by our Terms of Reference, which have an end date in June of 2021. But nevertheless, the Panel will consider that request, and it may be that before designing any recommendations we will call for further material in some form or another. It is unlikely to be by way of formal statements, but the solicitor to the Inquiry has written to Phoenix Law 11:56 11:57

to respond to a number of issues they have raised, including that, and I am sure that Phoenix Law will share that letter directly with their clients.

Hearing days will begin again on the 9th September, and we have a lot to deal with. As mentioned earlier, we still need to hear some evidence from the GMC and the Mental Health Commission, whether by way of written or oral evidence, as well as from the PSNI in Module 4, for which we will find time. 11:57 11:58

In the first week, we will continue with hospital staff witness evidence, before then turning to Module 7, which will look at the organisational and operative management of BHSCT and the hospital; Module 8, Professional Organisation and Oversight; Module 9 looks at the operation of the Trust Board and, finally, Module 10 will be evidence from the Department of Health. 11:58

We will sit from the 9th September until the end of October for the completion of the oral evidence. The proposal then is to take a break from the 30th of October to the 25th November, and we will then hear closing statements from Core Participants during the week of the 25th of November, and I will issue further instructions in relation to both written and oral submissions closer to the time. 11:59

There will, therefore, be, much to do over the summer, and we hope to provide the majority of the remaining statements for staff witnesses and the organisational modules by the first week of August of this year.

11:59

Finally, I want to thank all of those involved in this Inquiry for their hard work and dedication. We've had some very long days recently, and I would like to thank CPs and their representatives. I would like to give special thanks to Paula, our stenographer, for bearing with us and never complaining. I would like to thank our technical team, Eddie, Grace, and Tara, who make sure we broadcast appropriately and always seem to have the documents to hand. And, finally, to the counsel team, the solicitor's team, the admin staff, and the security staff, as well as those who make this hearing room and the statement showing process work so well.

11:59

12:00

We are very appreciative to our counsellors who have actually been here every day and who provided a significant amount of support to our witnesses. They do that quietly and in the background, but their work is essential.

12:00

Can I wish everybody a good summer and we will see you all back on the 9th September. Thank you.

12:00

THE INQUIRY ADJOURNED UNTIL MONDAY, 9TH SEPTEMBER 2024, AT 10:00 A.M.