MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 6TH JUNE 2024 - DAY 89

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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THE INQUIRY RESUMED AS FOLLOWS AFTER THE LUNCHEON ADJOURNMENT:

CHAIRPERSON: Thank you.

MS. BRIGGS: Good afternoon, Panel. This afternoon, we will be hearing from witness A14. The statement reference is 258, and there is an order for anonymity under Restriction Order 69. 13:52

CHAIRPERSON: Yes. And I think a note has gone out to CPs this morning in relation to how we're going to deal with this witness, because the statement that was served is very heavily redacted, some might think slightly over-redacted. And one of the issues that the Panel, and others, will need to know, is, for instance, where certain things happened on which wards. And so I think, throughout the statement, the wards have all been redacted, and I think you're going to cure that when you call the witness. 13:52 13:52

MS. BRIGGS: That's right.

CHAIRPERSON: So far as possible, obviously. 13:53

MS. BRIGGS: That's right. We will use ward names where appropriate and in a balanced way, to assist with the evidence, Chair.

CHAIRPERSON: Okay, excellent. Right, can we get the witness in? 13:53

A14, HAVING BEEN SWORN, GAVE EVIDENCE TO THE INQUIRY AS FOLLOWS:

CHAIRPERSON: 'A14' is how I'm going to address you, can I thank you very much for attending to help us this afternoon. Thank you for your statement. As you know, you've been anonymised and I expect you've spoken already to counsel about how that's going to work when you give evidence. So, I'll hand you over to Ms. Briggs. Thank you.

THE WITNESS: Thank you.

1 Q. MS. BRIGGS: A14, I have discussed with you the anonymity order and how we're going to deal with that, okay? As you know, we are going to use ward names where it's appropriate, and we've also discussed that if you feel that you need to use a name of someone else who you worked with, that there's a cipher list in front of you. And if you look at that list, first of all, and see if any name you want to use is there at any time. If it's not there, you can write the name down and the Secretary to the Inquiry will assist in getting that name for you, okay? 13:54 13:54 13:55 13:55

CHAIRPERSON: And can I just say this: If you do slip up and use somebody's name, don't panic about it, okay? Because we have a system whereby we can stop the feed that's going out of this room and we can alter the transcript, all right?

THE WITNESS: Okay. 13:55

2 Q. MS. BRIGGS: You've made a statement to the Inquiry.

A. I have.

3 Q. It's dated 20th May 2024. You have a hard copy of it in front of you there. It runs to 42 pages, okay? Do

you wish to adopt the contents of that statement as your evidence to the Inquiry?

A. I do.

Q. At the beginning of your statement, you gave us a bit of a background to your work in Muckamore, okay, and the overview is this: You worked at Muckamore from 1999 until 2001 as a student nurse, isn't that right? 13:56

A. That's correct, yes.

Q. And then you worked there as a registered nurse from 2001 until 2022, isn't that right? 13:56

A. That's correct yes.

Q. And it's fair to say that you worked mainly in female admission wards?

A. Mainly in female, yes.

Q. And it's also fair to say that you left Muckamore as a senior nurse, if we put it that way? 13:56

A. That's correct, yes.

Q. All right. At the beginning of your statement, you tell us that you obtained a diploma in learning-disability nursing, okay, and that was at Queen's University, isn't that right? 13:56

A. That's correct, yes.

Q. Okay. Thinking back to that degree and the placements that you did during that time, some of those were in Muckamore, isn't that right? 13:57

A. The majority of them were in Muckamore, yes.

Q. If you think back to that time, do you feel that that degree and the placements that you did adequately prepared you for your work as a learning-disability

nurse?

A. I feel in a way, but it depended on what wards that I was in. You know, some of the wards -- I wasn't in any of the admission wards for my placements, so it was mostly, you know, the other wards that I was in. So my first ward then would have been one of the admission wards when I actually started my job, so there would have been some preparation, but, then again, I suppose you don't fully experience any of your profession or your role until you're actually in the job. 13:57

11 Q. Okay.

DR. MAXWELL: So, when you started to work on admission wards and wards with patients with challenging behaviour, you're saying you hadn't developed enough skills in your preregistration training to meet those patients' needs? 13:58

A. No, no, I am not saying that. I'm just saying that I didn't work in any of the -- you know, the admission wards as a student, where you would have built up some of the skills from the other wards. 13:58

DR. MAXWELL: Okay. And preregistration training is quite broad, it's for practising in a very wide range of environments. So, when you did get onto a ward - I think you talk about Fintona North - with patients with challenging behaviour, did you feel that you were adequately equipped to deal with that? 13:58

A. I felt it was a bit daunting for my first ward, you know, again, as a new nurse, and there was a lot of registered nurses on the ward, so I felt, you know, it

was a welcome to me that the nurses were there to support me.

DR. MAXWELL: It's not quite the same as whether you felt you had the skills when you got there. Did you have to learn on the job how to do this? 13:59

A. Yeah.

DR. MAXWELL: And you were fortunate you had other staff nurses who could --

A. I had a lot of experienced staff above me, yeah.

DR. MAXWELL: Okay, thank you. 13:59

12 Q. MS. BRIGGS: What about your degree at Queen's in terms of teaching you about things like your duty to report safeguarding issues or whistleblowing, those types of things, do you feel that your teaching at Queen's and your time at Queen's adequately taught you about what 13:59 you needed to do if you were to whistleblow or if you were to raise concerns?

A. It's difficult to remember back to everything that I learned during my training, but again, then, that was shared with me during my inductions onto each of the 13:59 wards, about, you know, if I had to complain or about whistleblowing, it was shared with me on the wards during the inductions.

13 Q. You go on in your statement to tell us about the various wards you worked on, and there were a few. You 13:59 give a lot of detail about what it was like on each of those wards. I want to pick up at paragraph 13 on page 5, okay? And here, you're describing a patient who you nursed on your first ward, okay, and that's Fintona

North. And this, you're describing here a female patient who you say you built up a very good relationship with and you tell the reader there that you were her named nurse.

CHAIRPERSON: So, we're in 2001/2002 now, are we? 14:00

A. Yeah.

14 Q. MS. BRIGGS: How quickly then -- you started working in 2001. How quickly did it happen that you became someone's named nurse?

A. Well, I would have went through my induction first and 14:00 then, you know, when I sort of built up a better rapport with the patients and had a good knowledge of the ward, then I would have been appointed as a named nurse. I just can't remember exactly what that time period was. 14:01

15 Q. How long did your induction take then when you came into the ward?

A. So, the induction would have been over a number of days.

16 Q. Okay. So, it was sometime after that that you became a 14:01 named nurse?

A. I honestly can't remember.

17 Q. And can you remember - and I appreciate it's some time ago - can you remember how many patients you were a named nurse for in that early period? 14:01

A. It would have only been one in that early period.

18 Q. And did that change as you became more experienced and as time went on?

A. That would have changed depending on what ward I was

working in and depending, as well, on the amount of registered staff on the ward and who was able to, you know, able to take up that position of named nurse.

19 Q. And can you recall, for example, how many patients on average, if it was more than one at any given time or -- 14:02

A. On average, I may have had three.

20 Q. Three?

A. Yeah.

21 Q. Okay. 14:02

A. But that would have been the maximum I ever had.

22 Q. And that would have been later on during your time in Muckamore?

A. That's correct, yes.

23 Q. And did you ever have more patients than what you felt you could cope with in terms of fulfilling the role of a named nurse? 14:02

A. No, I don't recall that happening, no.

24 Q. And when you did become a named nurse for a patient, what kind of introduction would you have had to that patient? 14:02

A. So, obviously I would have built up the rapport with that patient, introduced myself and read their care plan, got information from all our staff and read any other assessments and documents in relation to that patient. 14:02

25 Q. And would there have been a handover then from the previous named nurse, or how would that have worked?

A. There would have been a handover, yes. And again, any

reviews would have been within the nursing notes.

26 Q. You describe at that paragraph 13 - it's on your screen - about halfway down that paragraph, you describe about having protected time to have one-to-one meetings with the patient for whom you were a named nurse, weekly. Was there always that time built in to meet with a patient and have those discussions, those meetings, or did that change? 14:03

A. It would have been down to the individual nurse and for that nurse to make that time, because if you were spending time on the ward with the patients and then, you know, there was other staff who were able to observe the remainder of the patients, you could have taken that patient aside and, you know, asked to have -- asked for their consent to have that one-to-one with them. 14:03

27 Q. So you say it was up to the individual nurse. So when you say the time was protected, what do you mean by that?

A. It was up to the individual nurse, but, you know, at the beginning of the day it may have been allocated or you might have just taken it upon yourself, because you were the named nurse and it was your responsibility to, you know, attend to that patient. 14:04

28 Q. So it's not to say that, on a weekly basis, time was set aside for you, as a nurse, to have those one-to-one meetings by your seniors? 14:04

A. On some wards, not on all wards.

29 Q. Okay.

A. And again, it depended on the staffing as well.

30 Q. Okay. You go on to describe other wards you worked on and one of the wards you talk about working on was children's ward --

A. Mm-hmm. 14:04

31 Q. -- Conacre. Page 6, at the start of paragraph 17, you say there that you found nursing on the children's ward quite challenging in the beginning as you hadn't worked with children previously. Had you received any training about working with children before you came to 14:05 work on Conacre?

A. No, I wouldn't have received any specific training to work with children, but their care plans and some of their assessments would have been similar, and again, there would have been experienced register staff on 14:05 that ward, you know, where I was able to get information and then again build up the rapport with the patients. Again, I think I found it quite difficult because I had primarily worked with female patients and now was working with male patients, so 14:05 just that change over to the male patient.

32 Q. The Inquiry has heard that, quite often on Conacre, it was actually late teenage boys that were the typical patient profile; is that what you experienced?

A. That's correct, yes, yeah. 14:05

33 Q. You say later on in paragraph 17, it's over on page 7, that there were staff shortages quite often on Conacre, and you say this, you say:

"I flagged staff shortages to the ward managers and the nursing office, requesting support when the ward was short-staffed due to staff sickness. On occasion, I would have contacted bank staff directly if cover was required."

What was the outcome when you raised concerns about staffing on the children's ward?

A. So, when we come in for the handover in the morning, you would have known how many staff you had on duty and how many staff you would have required. You would have contacted the nursing office and stated what your staffing was and was there anybody available on any other wards to support you on that ward. 14:06

34 Q. And what would the response have been? 14:06

A. Normally, you would have got staff to support you or, if you didn't get staff, we would have had, like, a phone book in relation to bank staff and we would have contacted them, and on 99% of occasions you would have got at least one staff member to support you. 14:07

35 Q. And what would have happened in those 1% of cases where you couldn't get that support?

A. Again, if I was the nurse in charge, I would have just had to put myself onto the floor as well and just done whatever my nurse in charge duties were from the floor, again always prioritising the patient. 14:07

36 Q. All right. I want to move on then to page 8 and through to 9. It's paragraph 20. This is you describing how female patients were moved from one ward

to another, and this is around 2016, okay? You're talking about the move from Cranfield to Killead.

A. That's correct, yes.

37 Q. And you give lots of information about that, okay? You describe how it was a very rash decision and it was very unexpected, the movement of patients out into Killead. Why do you say it was unexpected? 14:08

A. There had been --

38 Q. I'm just going to stop for one second.

MS. RICHARDSON: Chair, the feed hasn't been on in here in Room B. 14:08

CHAIRPERSON: Oh, it should have been.

MS. RICHARDSON: So we just need to pause, apologies.

CHAIRPERSON: That's our problem. This evidence is not fully restricted, there's simply an anonymity order, so the feed should be on to B. So apologies to those in B if they've missed any evidence, but there will, of course, be a transcript of it. Sorry. Thank you. 14:08

39 Q. MS. BRIGGS: A14, we were just -- I was just asking you there about the movement of patients from Cranfield to Killead, okay, which was around 2016, you say here at paragraph 20 of your statement. And you describe in great detail in that paragraph what it was like, that move, and you describe it as a very rash decision and you say it was very unexpected to have the patients move from Cranfield to Killead. Why do you say it was unexpected? 14:08 14:09

A. Staff -- like, senior management had discussed it and thought it may be a good idea because we were having

more female admissions than male admissions. We didn't have the capacity within Cranfield at that time. But there was no -- to my knowledge, there was no plans of when it was actually going to happen. So when I had returned from annual leave, I was informed that the staff were informed the day prior that the move was happening and they had to bring the patients, all their belongings and all the nursing notes and, you know, all the ward's belongings, they had to move it over the following day. So, again, I don't think it gave much preparation for the patients, the staff, the relatives, anybody, to consent to the move; I just feel it was done very quickly. 14:09 14:10

40 Q. And how did that impact the patients?

A. Again, the number of the patients increased because there was more beds within Killead ward. They were moved out of their comfort zone and they were moved into a different area, again getting accustomed to a different ward, a different bedroom, different communal area, different sitting rooms, moving in with patients they may not have known before. So, I found it very -- it was very stressful for the patients and staff. 14:10 14:10

CHAIRPERSON: And for some of these patients, presumably a regular environment is very important?

A. Yeah, so it wasn't conducive to a lot of their needs. 14:10

41 Q. MS. BRIGGS: You describe in the same paragraph how incidents increased after this move, and you've touched upon there how there was a bigger capacity, there were more patients, okay, on Killead, but you also discuss

how there was limited living space for everyone and other things, okay. What do you attribute the increase in incidents to; was it the fact of the move itself and the new environment for the patients? Was it the increased numbers? Was it how Killead ward was set up itself? Can you say? 14:11

A. I feel it was due to the increase in the patient numbers. Again, there was a large communal area, which all the patients wanted to be in the large communal area, but not all the patients, you know, got on with each other or agreed with each other. So then it would have been patients who normally wouldn't have mixed, and I just feel that there was a lot of different personalities and there was incidents occurring, again because they were stressed and there was -- you know, we had just moved over, there would have been - I'm trying to remember - there may have been one or two extra staff that had come in to assist us at that stage because of our larger capacity of patients. So, it was just -- I just feel it was very unsettling, you know, for the patients to get accustomed to that ward and their new environment. 14:11 14:11 14:12

42 Q. Okay.

PROF. MURPHY: Why was it done in such a hurry, do you think? What was the urgency? 14:12

A. The urgency was because there was more female patients being admitted to Muckamore at the time and there was less male patients, so they then decided to move the female patients over where there was more beds. So

that's my only understanding of why it was done in such a rush.

PROF. MURPHY: Well, of course, that doesn't totally explain it, in that an alternative could have been to have two female wards. 14:12

A. Yeah. I don't know if there would have been an alternative at that time, but again, it was a management decision. I wasn't in a management role at that time, so...

43 Q. MS. BRIGGS: I'd like to drill down, A14, on how staff were told about the move, because you've touched on it here. You say that you found out yourself about the move when you telephoned the ward to speak to the nurse in charge for your duty rota and you were told that you had moved. 14:13 14:13

A. That's correct, yes.

44 Q. And you go on to say towards the end of paragraph 20 at the bottom of page 9, towards the end of page 9, that you understand that the ward manager, staff nurses and nursing assistants were only told the previous day. 14:13

A. To my knowledge, that's what I was informed.

45 Q. So, if it was above the ward manager, who was only told the previous day, where do you think the decision and the management of the move, where was it coming from?

A. It was obviously coming from senior management above the ward manager. 14:13

46 Q. And you say later on that H77 - and you've got your cipher list there - you say that H77 was the senior nurse manager involved in enforcing the move?

A. That's correct, yes.

47 Q. Did he have any role in the decision-making?

A. He would have had a role in that decision-making, yes.

48 Q. And overall, you say that this move to Killead ward, you say that it was an example of poor care and you say it was poorly handle? 14:14

A. I feel it was poorly handled because there was no time given for patients or staff, you know, to come to terms with that they were going to a different ward. There was no preparation. You know, I can't exactly remember if all the relatives were informed, but again, they would only be informed the day prior or the day that they actually moved, so it just felt there was no preparation within that move, and there should have been for everybody involved. 14:14 14:15

49 Q. Did you raise your concerns at the time about this?

A. At the time, yes, I would have raised my concerns with the ward manager. Again, it was a very busy environment, we were taking care of our patients and ensuring that, you know, we minimise the incidents that occurred on the ward. So, again, you were sort of just thrown into it and you were just thrown into it and, you know, you just had to get on with your working day and make the best of that situation. 14:15

50 Q. And what did your ward manager say when you raised your concerns? 14:15

A. She had said at that stage it was out of our hands.

51 Q. I'm going to go on then at page 10, paragraph 22. As I say, you've given lots of detail before this about the

various wards you've worked on. This particular paragraph, you're talking about the last ward you worked on, okay, before you left Muckamore in 2022. You say at the end of the paragraph that, by that time, Muckamore had become an untenable place to work. At this point you were on Donegore, isn't that right?

A. That's correct, yes.

52 Q. What made it an untenable place to work?

A. Again, at that stage, I was the only substantive registered nurse on the ward. There was a lot of Band 3s or nursing auxiliaries that still remained on the ward, but in relation to all our registered staff, it was mostly agency mental-health-trained staff. So, I felt there was just an awful lot of pressure on myself, because I was doing, like, junior nurse duties, senior nurse duties, just the oversight of the whole ward, and I just feel I didn't have -- there wasn't the support there, you know.

53 Q. And you felt that those mental health agency staff, they weren't perhaps adequately trained or prepared to support you in your role?

A. They just would have used a different approach to the learning disability nurse.

CHAIRPERSON: So, at the point at which you left, how many registered LD staff would there have been?

A. On my ward when I left, there was none, no registered LD substantive staff on my ward. I was the last one to leave. There may have been roughly five to six between the other wards. So, there was --

CHAIRPERSON: In the whole hospital?

A. Yeah, yeah. There was very little LD staff.

DR. MAXWELL: You said the RMNs would have had a different approach to the RNLDs. Do you want to say a little bit more about that? 14:17

A. Yes, the different approach would have been, you know, if a patient was distressed or agitated, we knew our patient, we went in, we would have used de-escalation techniques, you know, verbal reassurance, before we would have moved anywhere towards PRN medication or 14:18 any -- you know, anything else restrictive. But I feel -- I remember on one occasion I had been in the office and one of the patients had been unsettled and the staff on the ward were dealing with it and, like, when I went out, like, five minutes later when I was 14:18 finished with what I was dealing with, I had asked, you know, the outcome and how the patient was and that patient had got an intramuscular, and I felt it could have been dealt with so much differently, you know, with staff that knew that patient. 14:18

CHAIRPERSON: Does that mean a PRN...

A. An intramuscular PRN, yeah.

DR. MAXWELL: So would it be fair to say then that the RMNs, the mental health nurses, didn't really understand that some of the behaviours were a form of 14:19 communication, subs [inaudible] they'd be used to restraining and using PRN in mental health units --

A. Yeah.

DR. MAXWELL: -- but was it that they didn't understand

that the patients might be trying to communicate something with their behaviours or...

A. It's difficult to know, because at that time they would have been aware of the care plan for the patient, the nursing assessments, the Positive Behaviour Support plans, but I feel they may have felt intramuscular medication may have settled the patient quicker. 14:19

DR. MAXWELL: So they were bringing things from their experience in mental health units that weren't necessarily appropriate -- 14:19

A. To the learning disability.

DR. MAXWELL: -- in the LD unit.

A. And again, with the learning disability patients, it may have taken a longer period for that patient to settle and you just would have had to have been, you know -- you would have had to sit with your patient and just sort of wait it out until they became that they were more regulated. But I just feel mental health nurses didn't have that same approach or didn't have that same tolerance towards, you know, a situation being -- just felt the situation should have been de-escalated a lot quicker. 14:19 14:20

DR. MAXWELL: So the logical conclusion from that is, if there are no LD nurses on the ward, we might expect the use of PRN to go up? 14:20

A. A lot more use of PRN medication, yes, that's my fear of the way Muckamore is left at present.

DR. MAXWELL: Okay, thank you.

54 Q. MS. BRIGGS: Thinking about the difficulties with

staffing at Donegore when you finished your time in Muckamore, did you raise any concerns about the level of staffing and the types of staff that you were working with?

A. I repeatedly raised concerns about, on occasions, agency staff that came in. We may have had information about these staff members prior, sometimes we didn't, a new staff may have turned up and I may have knew nothing about that staff member, so I just felt I was putting the patients and the ward at risk because we didn't know what experience that staff nurse had. Yes, I have to say there was some LD nurses that came through, some very good LD nurses and some very good mental health staff, but on occasions you were just left where, you know, you could have been -- there could have been three or four, maybe more, unfamiliar staff on the ward, and then I feel that unsettled the patients as well, because they were -- as staff left and staff were suspended, then the patients became a lot more unsettled because they didn't understand what was going on within the hospital. 14:20 14:21 14:21 14:21

55 Q. And who did you raise your concerns to?

A. So, I would have raised it senior managers at the time.

56 Q. And what was the response?

A. The response was, like, there was posts out for more LD nurses, but there was nobody applying. They had asked some of the community staff to come in. But then again, due to the inquiry -- or, sorry, due to the investigation, staff were anxious and reluctant to come 14:22

to the wards and it appeared that our only solution was agency staff.

PROF. MURPHY: We've heard from other witnesses that, at this sort of time, there was block booking of 50 agency staff. 14:22

A. That's correct.

PROF. MURPHY: So that you would get to know those staff. Was that right?

A. There may have been block booking, but depending on that staff member, some of them stayed with us for a 14:22 period, some of them may have came for a week and found it, you know, too challenging and they may have left. So there would have been a high turnover on occasions of --

PROF. MURPHY: Being the -- 14:23

A. -- agency staff, yes.

DR. MAXWELL: So are you saying there was a block booking with the agency, but they were filling that with different people?

A. They would have come for a block booking, but then, 14:23 again, depending on that staff member, you know, it varied how long they actually stayed on the ward. Yes, we did have some agency staff that I think still remain there and would have been there for maybe three or four years, but then a lot of them would have moved on very 14:23 quickly.

CHAIRPERSON: What proportion would have that sort of stability, as it were?

A. I can only really comment on my own, on the last ward

that I worked in, and, to my knowledge, there might be two to three of the original agency staff that commenced on the ward that still remain there.

CHAIRPERSON: Out of?

A. There could have been six to seven, you know, that started with us initially. 14:23

CHAIRPERSON: So, six or seven in total?

A. Yeah. But then more would have come as time progressed.

57 Q. MS. BRIGGS: I want to move on now to some of the other things you talk about in your statement, okay? Page 11, paragraph 24, you're talking here, I think, more generally about your time at Muckamore, but you can tell me if that's not right, okay? You say here: 14:24

"I do recall that there were some challenges for patients in the transition from afternoon to evening time. This could have resulted in aggression towards staff from patients or between patients." 14:24

And you go on to say that patient behaviours changed at night-time. Is this something you experienced right through your time at Muckamore or are you talking about a certain ward?

A. No, it would have been mostly through my time in Muckamore. Again, a lot of the AHPs and the management would have been off shift after five or six o'clock, there would have been no day care, there would have been, like, no structured activities outside the ward, 14:24

but we would have had some structured activities on the ward. So, I just felt that patients felt that a more difficult time, a more challenging time.

58 Q. And thinking about the behaviour change, sometimes there's a phrase 'sundowning' that's used about people living with dementia, how their behaviours might change or worsen really towards the evening time. Is that something that happens in people with learning disability, do you know that? 14:25

A. I don't know for certain, but I know their behaviours, again not all of the patients, but some of the patients became more anxious or their behaviours of challenge would have increased and they would have needed a lot more reassurance. 14:25

59 Q. And do you attribute that to the environmental changes around them on the ward at that time rather than anything to do with their own learning disability? 14:25

A. I attribute it more to, you know, the lack of other staff about, and it was just back to the nursing staff, the Band 5s, Band 3s, Band 6s, whoever was on the ward at that time. 14:26

DR. MAXWELL: And did you ever have twilight shifts to --

A. Yeah, we normally would have only had, like, the one twilight shift. But again, I mean, in relation to, like, management or all our AHPs and daycare staff, so sort of the structured activities for the day, you know, it was sort of winding down to night-time, and I just feel some patients found that quite difficult and 14:26

maybe more difficult to relax as well.

DR. MAXWELL: Yes, I appreciate that. So, you did have -- there was the possibility of twilight shifts?

A. There was.

DR. MAXWELL: Is that usually used to help with mealtime and putting people to bed, rather than the activities then? 14:26

A. Twilights would have come in and initially they would have helped with staff breaks and then they would have helped with any activities on the ward and then preparing people for night as well, for night-time, yeah. 14:27

60 Q. MS. BRIGGS: You describe towards the end of that paragraph, A14, about how you and other nursing staff would have organised activities for patients during that particular difficult time of the day. 14:27

A. Mm-hmm.

61 Q. Things that they liked and enjoyed. What kind of activities would that have been?

A. So, it would have been, like, tabletop activities like puzzles, colouring in; we would have maybe played bingo; there was jewellery-making at one occasion; we would have baked; if it was a nice evening, go for walks; on occasions, you know, around, like, Christmas time, Halloween, we would have had parties on the ward as well, yeah. 14:27 14:27

62 Q. Okay. You give lots of very detailed information to the Inquiry about admissions and care plans and treatment plans. I want to ask you a little bit about

behavioural support plans, okay? And if we go to page 14, it's at paragraph 29, and it's about halfway down that paragraph. You say this, okay, you say:

"I followed behavioural support plans, later known as PBS plans, where these had been formulated for patients. Only patients with behavioural issues who consented to engagement in their plans had a behavioural support plan." 14:28

What about a scenario where a patient's challenging behaviour was very extreme but they didn't consent to engagement in their plan, what would happen then?

A. If they didn't consent to engagement in their plan, you know, the staff would have continued to work with that patient and reassure that patient and, you know, try and follow the plan as best as they could. If we felt it wasn't working, again, the following day, we would have brought it back to the MDT, the behaviour team, and discussed what can we do different so that this patient, you know, is living a better life and, you know, maybe has a better understanding of what the plan is; do we need to share a social story with the patient? Do we need some, like, information that they can understand to help them, you know, to follow the behaviour plan? 14:28 14:29 14:29

63 Q. And how often might that have happened that a patient didn't consent to the use of their plan?

A. It wasn't that often.

PROF. MURPHY: So they did have a plan, even if they didn't consent? And your interpretation of what you needed to do was to try to explain to them why you were following the plan?

A. Yeah, it would have been guidance for staff to manage, you know, to manage their behaviours in an appropriate way that was conducive to their needs. 14:30

PROF. MURPHY: And do you think an equivalent respect was given to consent for medication?

A. In relation -- sorry, can you explain what you mean? 14:30

PROF. MURPHY: Well, it makes it sound like you had to consent to your PBS plan?

A. Not necessarily.

PROF. MURPHY: But you could get medication like PRN without, you know, without any argument, without any consent? 14:30

A. Again, any PRN medication would have been discussed with the whole MDT, and again, on observations and assessments of the patients. So, if we felt -- if the MDT felt that patient, you know, wasn't able to manage their own behavioural distress and they required PRN, but there would have been a lot of discussions around that. 14:30

PROF. MURPHY: Sure, sure. But that didn't apply to behavioural support plans? 14:31

A. Again, if the patient was -- again, due to capacity as well, if the patient was able to consent, the patient would have been involved in their behaviour plan, but if we felt the patient wasn't following the behaviour

plan, again we would have brought it to the table, you know, the following day or at the following meeting and tried to discuss, you know, what can we do different here for this plan to work for the patient.

PROF. MURPHY: Thank you. 14:31

64 Q. MS. BRIGGS: Picking up there on PRN, how often did it happen that a patient didn't consent to PRN and wasn't compliant and were given PRN anyway?

A. Again, you would have -- you would have needed consent from your patient to take PRN, because that person has 14:32 to actually take that medication and put it in their mouth, or allow the nurse, you know, to put it in with a medicine cup, so I feel unless it was intramuscular medication --

CHAIRPERSON: Well, I think the question includes 14:32 intramuscular.

A. Okay. Well, we didn't very often use intramuscular medication, that would have been like a last resort. We always would have tried maybe -- I can recall on numerous occasions coming back with oral medication, 14:32 you know, to prevent the use of intramuscular medication, because I felt sometimes it sort of broke the trust down of the patients.

65 Q. MS. BRIGGS: And when you had to get to that last resort of using intramuscular medication on a patient 14:32 who wasn't consenting, how often -- can you say how often that happened?

A. It wasn't very often, but the patient would have had to have been very distressed for us to, you know, consider

the use of intramuscular medication. Again, not all of our patients were wrote up for intramuscular, they would have only been wrote up for oral, so we may have had -- if we felt they required intramuscular, we would have had to get the doctor to actually prescribe the intramuscular medication and get all our -- you know, all our senior managers and, on occasions, you know, the behaviour nurses as well and they could have maybe used different interventions where we wouldn't have had to go down the line of intramuscular medication, but in my experience, it wasn't used that often. 14:33 14:33

66 Q. All right. I want to move on then to page 16, paragraph 34. You're describing in this paragraph how you performed audits, okay?

A. Mm-hmm. 14:33

67 Q. Some of those were care plan audits. I want to ask you about those specific types of audits, care plan audits, okay. What did a care plan audit involve?

A. So the care plan audit involved, if the care plan was being reviewed on a regular basis, if the patient was included within the care plan, if they were informed of any reviews in relation to that care plan and if everything was actually documented in the care plan that was required. 14:34

68 Q. So, how often would you have been doing that audit? 14:34

A. Again, it varied on whatever ward that I worked in, but we tried do it at least every three months.

69 Q. Every three months per patient?

A. Yeah, but again, that varied.

70 Q. So, is your evidence then that all patients would have had their care plans audited?

A. That's correct, yeah.

71 Q. And it would have been, roughly, in a three-month period? 14:34

A. That's correct, yes.

72 Q. And did you follow the audit up with the named nurse for the patient, for example?

A. Yes, there would have been a pro forma that we, you know, documented on and we would have addressed that to 14:35 the named nurse and what was required and, sort of, like, a time as to when we wanted that actioned.

73 Q. And was that audit required by policy or why did you do it?

A. It was what we had used at the time. It was the 14:35 documentation, the care plan audit, and again, it was up to the senior nurse to ensure that that was followed for the best care for the patient.

DR. MAXWELL: Was this a Trust-wide policy that you were following? 14:35

A. It would have been a Trust-wide policy, but I think the format that we used may not have been the same as other formats, yeah.

DR. MAXWELL: Yes. So it had been customised for LD --

A. It had been, yes. 14:35

DR. MAXWELL: -- but it was a Trust-wide policy that nursing care plans are audited --

A. That's correct.

DR. MAXWELL: -- and discussed with the named nurse who

is responsible for them?

A. Yeah, to my knowledge, yes.

74 Q. MS. BRIGGS: In another part of your statement, you describe the use of allied health professionals at Muckamore, and this is at page 17, paragraph 36, and you give a lot of information to the Panel about speech and language therapists and physiotherapists and you're describing at that paragraph about how you would have referred patients on to those allied health professionals. How often would you have seen the likes of a speech and language therapist or a physiotherapist on the ward? 14:36 14:36

A. Again, that varied within the time that I was there, but in relation to occupational therapists, they may have been on the ward two to three times a week. The speech and language therapist was when you made a referral and that person needed assessed, you know, if there had have been a choking incident or if they had already come in with SALT recommendations from the community, you would have asked for that, you would have referred them on to the speech and language therapist to be reviewed on the ward to see if that still remained the same or if there was any changes within their recommendations. 14:36 14:37

75 Q. So, overall, did you feel that they were visible on the wards? 14:37

A. They were visible, but again, in the later years, there wasn't as many of them about.

76 Q. Yes, that's something you talk about, I think it's at

paragraph 56 on page --

CHAIRPERSON: Sorry, just before we move on, I just want to ask about the role of OTs, because occupational therapists can be very useful, I think, in terms of resettlement and people moving out into a more homely environment, but how often would an OT see a patient on the ward? You say you'd see them on the ward two or three times a week? 14:37

A. Two or three times a week, yeah.

CHAIRPERSON: Does that mean they'd get around every patient? 14:38

A. They wouldn't have been working with every patient, but they would have come in and worked with the patient that they were assigned to or, you know, that the patient that required that input at the time or the patient that was preparing for discharge. 14:38

CHAIRPERSON: So was that really focused on discharge, the OT's involvement?

A. Sorry?

CHAIRPERSON: Was that focused on resettlement or discharge, the OT's involvement? 14:38

A. No, no, it wasn't always focused on resettlement and discharge; it was focused on, you know, activities while they were in Muckamore as well, you know, and they would have been part of our MDT and they would have been at weekly meetings as well, and if we felt that they required more input or an additional input, we would have e-mailed or, you know, phoned the occupational therapist. 14:38

CHAIRPERSON: And would that be the same with SALTs?
A. That would have been the same with SALT, yes. Again, we could make referrals through PARIS or we could contact them directly.
DR. MAXWELL: So, just to be clear, all the patients had a named nurse and a named consultant? 14:39
A. That's correct.
DR. MAXWELL: But the allied health professionals would see the patients it was decided they would benefit from, so some patients wouldn't see a SALT and some patients wouldn't see an OT, but the team would decide collectively who would benefit from that? 14:39
A. Well, if a patient had no speech difficulties, no communication difficulties or no swallowing difficulties, then there would have been no reason for input for a speech and language therapist, unless, again, you know, if there was communication difficulties, there would have been a need for Social Stories, so again, it was individual to each patient and what input they required. 14:39
DR. MAXWELL: And would that also be true of the OTs and physios, that they wouldn't necessarily see every patient but they would see those who the team felt would benefit from it?
A. Who they felt, you know, who was referred to them, but they would have been involved in regular meetings with us, and if they felt if they were any -- they would have been of benefit or any input to the patient, then, you know, we would have discussed that with them and 14:40

they would have come and discussed it with us. They were aware of the patients we had on the ward and of their needs.

DR. MAXWELL: But the speech and language therapist wasn't based at Muckamore, didn't come to the MDT; that would be a formal referral? 14:40

A. No, they were based at Muckamore. In the last few years, they were based.

DR. MAXWELL: The SALTs?

A. The speech and language therapists, yeah, they were, yeah. I know, I think within the last year before I left, there was no speech and language therapist who was based in the hospital, but, no, the speech and language therapist was based in the hospital and I could have e-mailed her or phoned her, you know, and asked her to come over and engage and assess some of the patients. 14:40 14:40

DR. MAXWELL: Thanks.

77 Q. MS. BRIGGS: A14, you touched, a few questions ago, on the reduction in AHPs towards the end of your time at Muckamore, and this is something you do address in your statement, it's at page 30, paragraph 56. You're saying there that, initially, there was sufficient input and support from AHPs and psychologists, but in the more recent years before you left Muckamore, that that support became limited, and you say how some of them were split between Muckamore and community care. 14:41 14:41

A. That's correct, yes.

78 Q. So you felt the loss of those AHPs towards the end, and

the psychologists, is that fair to say?

A. That would be fair to say, yes.

79 Q. And on the topic of social workers, you say here:

"In the last few months of my time at Muckamore in 2022, there was no social worker support. Two permanent social workers in Muckamore had retired and were never replaced." 14:41

How did the loss of AHPs and psychologists and social workers, how did that affect patient care at Muckamore in that later time? 14:42

A. You didn't have that expertise, and I felt, especially in relation to the social worker, they would have had that input with the -- you know, with the finances of the patient and contact with the family, contact with legal services, so I felt that was a great loss to the patients on the ward. 14:42

80 Q. I want to move on now and ask you about Positive Behavioural Support, okay? If we can go to page 24, paragraph 48, you give us a lot of detail about PBS, or Positive Behavioural Support, and what that is, and you say here towards the start of paragraph 48: 14:42

"Some patients had PBS plans, with detailed assessment and behaviours, with a traffic light system which helps staff and carers understand the different stages of behaviour. The patients' behaviours were categorised into different levels, graded green, amber and red, 14:43

which translates at proactive, early warning signs and reactive."

Can you give us a practical example of how the traffic-light system worked? 14:43

A. So, in relation to the green, the proactive, you know, that would have been when the patient was settled and there would have been no behavioural issues, and again, that would have been all the proactive work that the staff were doing on the ward to keep that patient at 14:43 baseline.

Then, the amber was when the patient would have been becoming distressed - you know, they would have been showing early warning signs. Again, if you knew your 14:44 patient and you knew their PBS and you knew if they were becoming distressed or agitated, then, again, there was techniques within that, different approaches that you could have used, individual to your patient, to help that patient to calm. 14:44

Then, when it came then to the red strategies, again your patient was very heightened and you had to -- you know, it may have been the use of PRN medication or it may have been the use of safety interventions when that 14:44 patient sort of had got very heightened, and then it was difficult to bring them down unless you were able to do it within the early stages.

81 Q. And how was it communicated? Would it be said "oh,

this patient, they are on an amber", would you say that amongst staff, or how did it work in practice? How did you know what level a patient was at and was it written down? I just want an idea of how the traffic-light system was actually used.

A. Well, the PBS plan would have been shared with ourselves and we then would have shared it with the nursing auxiliaries. If there was any changes, you know, within our, like, safety briefing, our handover in the morning, we would have, you know, we would have shared if there was any changes in that person's presentation and that the patient was on a PBS plan. Anybody new that came onto the ward, they were asked to read the patients' PBS plans.

82 Q. So, did a PBS plan, did it look like a set of colours, the traffic light colours, with an indication of what --

A. It would have been a document.

83 Q. A document?

A. Yes.

84 Q. With red, amber, green, and it would have said what the patient's behaviours were like beside in each category?

A. That would have been within the middle of the document. But at the beginning of the document, it would have explained, you know, information about the patient and behaviours of that challenge that that patient may have experienced.

DR. MAXWELL: Can I ask about that, because that's something that requires some knowledge and skill. So,

how did the registered nurses supervise the healthcare assistants in the use of the Positive Behaviour Support Plan?

A. Again, prior to the investigation, we would have had registered nurses on the floor and they would have been supervising and overseeing, you know, the work of the HCAs along with the patients and they would have been role-modelling what was in the nursing assessments and the PBS plans. Again, in the later years, it was more difficult. Again, we would have shared it at handover, shared it at staff meetings. Again, myself coming onto the floor and sharing it with the staff and role-modelling. But it just became more difficult because you had more responsibilities. 14:46 14:46

DR. MAXWELL: So, if -- when there were enough registered nurses, if healthcare assistants or nursing auxiliaries were working with a patient and they were starting to get anxious, would they then alert the staff nurse, who would come and say "yes, this is definitely an amber behaviour, these are the interventions we should be doing", or were they expected to know that and just get on with it? 14:47 14:47

A. Again, it varied. The staff nurse may have been on the floor and may have been experiencing, you know, observing that behaviour and they would have worked together and the staff nurse would have role-modelled the -- you know, the approaches to use with that patient. Again, a lot of the patients that I worked with had been there for a long time, so the nursing 14:47

auxiliaries became very familiar with the patients and knew the best approaches to, you know, manage different behaviours.

DR. MAXWELL: And at the end of the shift when you're writing up the progress notes, would you make reference to the fact that a patient had moved to an amber or a red behaviour in your shift progress note? 14:48

A. We wouldn't have always necessarily used that language, but we would have used, like, "de-escalation skills were used", "patient was becoming heightened", what approaches that were used that helped that patient to, you know -- or helped the de-escalation to become, you know, to progress, and then sort of the outcome of that de-escalation. So, we wouldn't have necessarily used the different colours or them different approaches within our nursing notes; that would have been more for the behaviour team then to record if they -- you know, again, within daily meetings or weekly meetings or their different interactions with the patients. 14:48 14:48

DR. MAXWELL: But you would definitely expect the named nurse or the nurse in charge at that time to record that one of the interventions on the Behaviour Support Plan had been used? 14:49

A. Yes, that's what -- yeah. But as I say, we wouldn't have necessarily used the different colour coding. 14:49

DR. MAXWELL: No, that's fine.

85 Q. MS. BRIGGS: A14, I want to turn now to incidents involving patients and staff, okay? This is at page 27, paragraph 53. About one-third or halfway down that

paragraph, you say:

"Incidents were discussed at live governance meetings each Thursday, which was normally chaired by a Band 8b or 8c. Each ward prepared their report for this meeting, detailing all the incidents in the previous week on their respective ward. Learning from these incidents were shared with all the wards and this forum gave each ward an opportunity to share their expertise on what other interventions or approaches could be utilised to minimise incidents."

Can you remember what year, approximately, those live governance meetings began?

A. Possibly, 2020/2021. 14:50

86 Q. Thank you very much. You go on to give a very detailed --

DR. MAXWELL: Sorry, just before you go on. So, what happened before 2020 to look at the trends in what was happening? 14:50

A. We would have discussed it at ward manager meetings. Again, any trends, when the Band 6 or Band 7 was approving the incidents, you know, they would have shared that with the MDT, but there was no actual forum to, you know, prior to the live governance, to discuss it with the remainder or the other wards, so that wouldn't have been in place. 14:51

DR. MAXWELL: So would you have got a report from Datix saying there are this many incidents reporting of this

category?

A. That's something you would have had to request.

DR. MAXWELL: Okay.

87 Q. MS. BRIGGS: A14, you go on in the next paragraph and over on the next page to give a very detailed and very personal account of a patient who you had had physical incidents with and other staff as well who were affected by that, and I don't intend to read that out, I know that's very difficult, all right? But I just want to ask you about the support that you got after those types of incidents happened, okay? And this was on Killead ward. 14:51 14:51

A. Mm-hmm.

88 Q. About halfway down that paragraph on page 28, you discuss one particular assault that you suffered by the patient and you describe how - about halfway down - you say you were emotionally supported and reassured by your colleagues, but you don't recall any other support from the Trust at the time. How were you supported by senior managers, if at all? 14:52 14:52

A. Again, on that occasion, the behaviours of challenge would have been frequent with, you know, on our patients and with staff members. I feel, unless you actually went off on sick then, you know, you were maybe asked how you were or whatever, but there was no other specific support, other than from your colleagues, or if you had requested, like, a referral to occupational health. 14:53

CHAIRPERSON: Could I just ask for the screen to be

moved to the top of page 29, rather than lingering on that incident.

DR. MAXWELL: Can I ask then, was there an expectation that this was part of life as an RNLD, that these were distressed patients, didn't necessarily know what they were doing, and being injured was just one of the hazards of the job? 14:53

A. It nearly was just an expectation. That was just part of your role. And again, you just became quite resilient and, you know, again, you didn't want to break down that relationship with the patient, so you would have, as much as possible, worked with that patient, but again, keeping the patient and yourself safe. And then if you felt that you were a trigger to that patient, removing yourself and allowing other staff to work with that patient. 14:53 14:54

DR. MAXWELL: But was it the expectation of senior managers that that just went with the territory, that sometimes staff would be injured?

A. It probably would have been expectation, because, again, some of these patients had been with us for a long time and their behaviours didn't really change. They would have been on Behaviour Support Plans, but it didn't really seem to change a lot of their behaviours. 14:54

PROF. MURPHY: So were you at least offered a possibility of a change in ward, which might have been one option? 14:54

A. At that time, no, that wasn't an option, no, and again, it was due to the reduced staff members and registered

staff within the hospital.

PROF. MURPHY: Yes.

89 Q. MS. BRIGGS: You say there at the end of that paragraph, and it's on the screen, that, after another incident, a psychologist and counsellor was discussed, but you weren't in contact with one. Was one actually offered to you at that point? 14:55

A. So, at that point, I had been off, I think it was after two incidents, and I'd been off on sick leave. I had discussions with the -- or was in contact with occupational health, and at that stage a psychologist was offered. But again, the staffing on the ward was reduced, I'd already been off in the region of two to three months, I was aware that staffing on the ward wasn't good and, again, I felt guilty, so I returned to work and didn't take the offer of that. 14:55 14:55

90 Q. Thank you, A14. I'm going to move on to something else now, okay?

A. Okay.

91 Q. And that's the use of CCTV at Muckamore, which you address in various parts of your statement, and you give lots of information about it, okay? I want to start off by looking at page 30, paragraph 56. It's about halfway down that paragraph. You're talking about contemporaneous viewing of CCTV. You say that this was post-2017 and you say that: 14:55 14:56

"Contemporaneous viewing for this was occurring and initially we would have been sent reports on what was

viewed and the viewer's interpretation of what they viewed."

And then a sentence on, you say that:

"The ward manager would have received these reports and these would have been printed and left in the staff base for staff to review. In the last year-and-a-half, approximately, we did not receive any reports of contemporaneous viewing." 14:56

When those reports stopped coming through, what effect did that have on staff?

A. Again, we weren't informed that, you know, that it was being stopped, and staff were asking me, you know, why were we not getting them reports. And I wasn't able to answer that, because I hadn't been informed why they were stopped. I had asked the question, but nobody was really able to answer me. I felt, in a way, too, that, you know, the reports, it was somebody who didn't work on the ward - somebody, maybe, who'd no knowledge of the patients and their interpretation, which may have been different to what actually occurred on the ward, you know, at that time. So, I don't think, at times, the reports were helpful. 14:57

92 Q. So, when they stopped, was that a relief for staff or how did staff feel about that?

A. A relief, in one way, but then, you know, the question as to why they had been stopped and why were the

reports not being shared any longer.

93 Q. You go back to the topic of CCTV later on in your statement, pages 37 through to 39. I'd like to see page 38, in particular at paragraph 75. In this paragraph, you're describing how CCTV was used to investigate incidents at Muckamore, and you say this, you say: 14:58

"I think the CCTV used to check incidents and allegations was open to interpretation. I recall occasions where I was called by the safeguarding team to identify staff members on CCTV and give my interpretations of what happened during an incident." 14:58

Then, one sentence later, you say: 14:58

"I don't feel that my interpretation of events and incidents was listened to by the safeguarding team."

And eventually you go on to say in that paragraph that you felt, and the later paragraphs, that you felt that nurses were only called to the CCTV room to identify staff, rather than, ultimately, give an opinion. Did you raise your concerns about the way that the CCTV viewing was being done at that time? 14:59 14:59

A. At that time, yes, I would have raised concerns to senior management, you know, and I felt that we were only over there for identification purposes. Again, we knew our patients and we could interpret what had

actually happened in them incidents, but again, I don't feel anybody listened to us. I did escalate it to senior managers, but I feel they were at a loss, as well, as to know what to do. And again, because of, then, you know, the investigation happening and because of safeguarding, the safeguarding team were in Muckamore at the time, they were within, you know, the setting, and it was just -- at that stage, we just felt that, you know, they were there, we just had to comply with whatever they had requested to ensure the safety of the patients and the staff. 14:59 15:00

94 Q. I want to talk now about the managers and the management style at Muckamore. At paragraph 62, on page 32, you're discussing managers and management style. You say in the second -- the third sentence there that you got on better with some managers than others and you don't think that's particularly remarkable. You do feel that the managers changed a lot, and you say: 15:00

"As time went on, I felt that some of the managers coming into Muckamore weren't very fair and were unnecessarily critical of practices and questioned things without reason." 15:00 15:01

You go on to give an account of some issues that you had relating to H294 and you say that you felt that H294 wasn't very good at dealing with incidents or families. Do you put the issues with H294 down to a

lack of experience or a lack of understanding or something else?

A. Lack of experience and a lack of understanding and then a lack of wanting to understand or listen to the staff and try and understand the patients. So I just feel that that person, you know, had come in with an agenda and was just following that agenda and wasn't listening to the staff on the floor.

95 Q. And what was that agenda?

A. I feel that that agenda was just to continue with trying to resettle patients, but, again, not taking into consideration the behaviours of the patients or any of the concerns that we would have raised or how to, you know, approach incidents that were conducive to that patient's needs.

96 Q. All right.

A. I feel that that person put herself and others, patients and staff members, at risk with her actions.

97 Q. You touch upon more senior management at paragraph 69 on page 35. I just want to pick up on something you say there. At that paragraph, you're discussing the visibility of senior staff and managers on the wards and you say that, in the later years, you saw the Band 8s quite regularly because they were based on the wards now, but you didn't really see anyone more senior than that at directorate or board level?

A. No, nobody -- it would have been very infrequent that, you know, anybody from that level would have been -- they may have been in the hospital, but not necessarily

on the wards, and we wouldn't have always been informed when they were in the hospital.

DR. MAXWELL: We have heard from other witnesses that having lots of people come into the wards would distress patients at times. Would you have thought it was a good or a bad idea to have lots of senior managers come onto the ward? 15:03

A. Again, the senior managers, you know - well, especially in the last ward that I worked in, the senior managers wouldn't have necessarily had to come through the ward, so the patients wouldn't have been aware they were on the ward, so they could have come and spoke to staff, you know, that were in the office or within the staffroom, without actually coming onto the ward. So I actually do agree that, you know, a lot of people -- it would have been distressing or it would have unsettled some of the patients, but they didn't always have to necessarily go through the ward; they could have come directly to the nurse in charge. 15:03 15:04

DR. MAXWELL: So, it wouldn't necessarily have been a good idea for them to come and see staff interacting with patients, but it probably would have been a good idea to come and talk to the staff? 15:04

A. Yeah.

CHAIRPERSON: And what would you have wanted to hear from them? What would you have expected them to be telling you? 15:04

A. Well, what I would have wanted was, you know, we have a lack of LD-registered staff within the hospital and

we're getting a lot of agency staff in, and what was our plan B and how could we encourage or entice more LD staff to come onto the wards, but I think --

CHAIRPERSON: So, a bit of to and fro, a bit of communication? 15:05

A. Yes, yes. And really just to, you know, raise our concerns about the lack of LD staff within the wards and how that was unsafe for patients and staff.

CHAIRPERSON: So, what opportunity did you have to do that? 15:05

A. Very little opportunity. Especially within the last few years, I had very little opportunity to, you know, express my views or to escalate them, other than, on occasions, e-mails, but they weren't always responded to. 15:05

CHAIRPERSON: But might that have changed your mind about leaving if you'd had that sort of communication?

A. I feel, because of the lack of registered staff, and I just feel that support network had been lost, so I don't think it would have, it would have changed that. 15:05

DR. MAXWELL: Can I ask you, did you ever speak to your professional college or union about the difficulties?

A. I would have spoke on one occasion, but that was just in relation to a complaint, but no.

DR. MAXWELL: Well, I'm assuming you are a member of a union or a professional college? 15:06

A. I am, yeah, yes.

DR. MAXWELL: They didn't ask, collectively, how their members were feeling, didn't make representations to

the Trust on behalf of their members?

A. Not that I can recall, but that may have happened, but again, you know, within the last few years, there was a lot of pressure on the staff that were left on the wards, and again, your main priority would have been ensuring, you know, you were prioritising the patient, looking after the patient. 15:06

DR. MAXWELL: No, I appreciate that, and I appreciate, you know, individuals may have an individual relationship, but often when there are a number of people, members, who are concerned, a union or a professional college will actually take the initiative and call a meeting and ask its members. That never happened, as far as you remember? 15:06

A. But I do remember some of my colleagues going to the likes of RCN, you know, and expressing their concerns, but I wouldn't have always had contact with RCN. 15:07

DR. MAXWELL: Okay.

CHAIRPERSON: I'm just thinking about timing. You've been going about one hour and five, ten minutes. Very often, we take a break about now. 15:07

A. Okay.

CHAIRPERSON: Ms. Briggs, how long do you think you will be?

MS. BRIGGS: 10 to 15 minutes, Chair, not very long 15:07

CHAIRPERSON: Right. I'm going to leave it with you. I'm very happy to take a break if you'd like to take a break, or do you want to get through the rest of it?

A. I'll take a wee break, if that's okay?

CHAIRPERSON: A wee break, yes, absolutely. Okay, we'll take a ten-minute break and then we'll see you back. You will be looked after by Jaclyn. Thank you.

SHORT ADJOURNMENT 15:07

CHAIRPERSON: Just give me a second, sorry.
(Short pause)
Yes.

98 Q. MS. BRIGGS: A14, I want to look at clinical supervision a little bit, okay? And I'm going to ask for paragraph 66 on page 34 to be pulled up, and you say there: 15:22

"I did receive clinical supervision at times by my manager. In more recent years, my time was limited due to staff shortages, so I did not receive this as often. I received clinical supervision approximately every six months." 15:22

15:23

And you go on to discuss what that supervision involved. Are you saying that "every six months" was in the later times when it wasn't so often or was it six months earlier than that, every six months?

A. It would have been previous to that. And in the later time, it would have been, again, all of us would have had -- you know, it wouldn't always have been necessarily documented as clinical supervision, but I would have had, you know, discussions in relation to, 15:23

you know, my own -- sort of my own practice and then concerns that I had on the ward and anything that I wanted addressed. But probably within this last year or two that I was there, it would have been documented probably on a yearly basis. 15:23

99 Q. And thinking about when it was every six months, before those difficulties came in, do you think that was enough?

A. I feel it probably could have been more often, but, I know, you know, it's required every six months. But I 15:24 feel there would have been concerns and issues that we could have addressed officially more often, yeah, within clinical supervision.

100 Q. How often do you think would have been a better period?

A. Probably every two to three months. 15:24

101 Q. Okay. At the next paragraph, paragraph 67, at the bottom of page 34, you're discussing CPD, or continuous professional development, and you say you've received protected time for it, and you go on to say sometimes it didn't go ahead and it was cancelled due to the work 15:24 pressures and the resource pressures within Muckamore. Was that type of cancellation for CPD, was that something that you experienced throughout your time or was that more towards the end when the difficulties that we've discussed came -- 15:25

A. It would have been more towards the end.

102 Q. Paragraph 68 on page 35, you're telling the Inquiry here about a study in quality improvement that you undertook in 2019. You say this, you say:

"My study focused on aggressive behaviours and strategies and activities that we could implement to reduce these aggressive behaviours. My study showed that aggressive behaviours did reduce with addition of extra activities." 15:25

And you say what those might be. Who was guiding your study; was that one of the universities?

A. Yes, it would have been the university, and I would have had, like, a mentor in to guide me through the study. I would have attended some sessions, I think it was in the City Hospital, where, you know, we were sort of collectively coming together from different areas within the Belfast Trust, and there was myself and another colleague who done the quality improvement within Muckamore on that occasion. 15:26 15:26

DR. MAXWELL: Was this part of the IHI, the Institute for Health Improvement, programme? Did you do driver diagrams and -- 15:26

A. Yes, yes, yes.

DR. MAXWELL: So, I think that was a programme throughout the Trust, wasn't it?

A. It was, yeah, but that was my first experience.

DR. MAXWELL: Not necessarily -- it wasn't a university course; it was something the Trust was running? 15:26

A. Throughout the Trust, yes, yeah.

103 Q. MS. BRIGGS: And did you produce a report at the end of it?

A. There was a report at the end of it, yeah.

104 Q. And when that report was produced, did management at Muckamore, or elsewhere, did they accept your findings and put in place more activities?

A. We had put in place -- there was an activity coordinator that was employed within the hospital at the time and I sort of done my own research and got different activities and what I thought, along with my colleagues on the ward, which we thought would have benefited the patients, so we sort of sourced them with the help of the activities coordinator. It remained in place for a short time after, but again, that person wasn't -- to my knowledge, wasn't employed by the Belfast Trust, so there was no money in place for that person to remain within the hospital, so it was short-lived. 15:27 15:27 15:27

CHAIRPERSON: So, I'm sorry, who paid for it?

A. So, it would have been Muckamore or the Trust that would have paid for it. It was additional to what our finances were for Muckamore. 15:28

DR. MAXWELL: So, Muckamore found the money within their budget rather than it being --

A. Yeah. So, it would have come out of, like, daycare money at the time.

CHAIRPERSON: Oh, I see. 15:28

105 Q. MS. BRIGGS: The very final thing I want to ask you about is the effect on Muckamore, its staff and its patients, of the abuse allegations becoming known, okay, in 2017. At the very end of your statement - and

this is at page 39, paragraph 78 - you say:

"When the allegations of abuse of patients came out, I was shocked and distressed as I personally had never witnessed abuse in Muckamore. Learning disability nurses left and were suspended." 15:28

A couple of sentences on, you say:

"This resulted in a lot of nursing vacancies in Muckamore and agency staff had to support the hospital." 15:28

And you describe, and you've already described, the difficulties that were faced with agency staff. How could all of that have been better handled? 15:29

A. I feel at the time that, you know, obviously it was all publicised and it made staff very anxious, it made staff -- people were being suspended, you know, sometimes, like, on a weekly basis; staff weren't made aware prior to that suspension or weren't informed of what they were being suspended for. So, it just made the rest of the workforce very uneasy and very anxious. How it could have been handled better, I feel maybe there should have been more people coming in, more management, maybe, from the Trust, or whatever, coming in, trying to reassure the staff that remained on the floor... sorry, yes, to reassure them, and maybe even to discuss, you know, what the plan is going forward. 15:29 15:29

We would have been informed there would have been more -- you know, that incidents were being looked at and more safeguarding was in place, but we weren't necessarily told what wards were going to be -- you know, the CCTV, what wards were going to be looked at, you know, and sort of what the progression of that was. So, staff were just very uneasy. And again, as I say, a lot of staff were just wanting to leave the hospital, because it was very uncertain, the future, for everybody involved. 15:30

106 Q. At paragraph 79, over the page, you describe how, at that time, post the allegations of abuse coming out and being made public, you say that there was a counsellor offered to staff and you say this, you say that you think that there were occasions when you should have used the service yourself and spoken to the counsellor, but due to time constraints -- you say: 15:31

"I did not attend this service as my time was limited and I had so many responsibilities on the ward due to lack of registered learning disability staff." 15:31

Were you actually given the time to see the counsellor?

A. That would have been up to yourself, so, no, I wasn't necessarily given that time. It would have been up to me to contact the counsellor, and that could have been in work or out of -- sometimes, out of work as well. 15:31

107 Q. Should you have been given that time?

A. I feel I probably should have been given that time, but

there just wasn't the staff to, you know, replace me while I was on duty.

MS. BRIGGS: Okay. A14, that's all the questions I have for you. The Panel might have some questions.

15:32

THE WITNESS WAS THEN QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

108 Q. CHAIRPERSON: Just a couple of questions from me. You were just touching upon it then; when all of the allegations came out and people were being suspended, did you have any communication from the board of the Trust, you know, the really high level, did anybody come down and talk to the staff? 15:32

A. Well, from the Trust, there would have been directors that would have come in and there would have been different meetings, but I don't recall -- 15:32

109 Q. CHAIRPERSON: Tell us a bit about that. Did you attend any of those meetings?

A. I would have. I attended, I think, two of them, yes. So, it would have been held within Muckamore and it would have been explained to us, you know, if we had any concerns, that we could have addressed them, but I suppose, at that stage, there was only so much that even the Trust knew, because of the investigation and then the public wanting a public inquiry then. 15:32 15:33

110 Q. CHAIRPERSON: So, was that right at the beginning or when was that?

A. I'm trying to recall when it was. It may have been --

I don't know exactly, but it may have been 2019/2020.

111 Q. CHAIRPERSON: Right.

A. To my recollection.

112 Q. CHAIRPERSON: A completely different question and one you have not been asked about, but I presume during your time at Muckamore you did a number of night shifts? 15:33

A. I done a few night shifts, yes.

113 Q. CHAIRPERSON: And I just want to understand the regularity with which patients might come out of their rooms when you were on a night shift, either for comfort or for food or for reassurance or something else. Was that a very rare occurrence or a frequent occurrence? 15:33

A. Again, it depended what ward you worked on. We would have checked on the patients regularly anyway, so some patients may have been unsettled and it may have taken them, you know, a constable amount of time for them to settle and to sleep. But it wasn't a normal occurrence within the wards that I worked in. 15:34 15:34

CHAIRPERSON: Okay, thank you.

114 Q. DR. MAXWELL: And how often did you do a round to check patients who appeared to be asleep or content in their room? Was there a minimum period that you would go and check -- 15:34

A. We would have done hourly checks.

115 Q. DR. MAXWELL: Hourly checks?

A. Yes, mm-hmm, yeah.

116 Q. DR. MAXWELL: And did you ever use the intentional rounding forms, did you ever sign to say you had done the checks?

A. We would have documented within the progress notes that the checks were completed. 15:34

DR. MAXWELL: Okay.

CHAIRPERSON: Okay. Can I just thank you very much for coming to give your evidence. I know that you found it quite stressful to come here -- 15:35

A. Yeah.

CHAIRPERSON: -- but I hope your experience of actually giving evidence was far easier than the anticipation.

A. It has been, it has been easier, yes, yeah.

CHAIRPERSON: Good. Well, I hope others can take 15:35 reassurance from that. Can I thank you very much indeed for coming along to help us, and you can now go with the Secretary to the Inquiry. Everybody's got to stay in the room, I'm afraid, until the witness has cleared the building. Thank you very much. 15:35

THE WITNESS THEN WITHDREW

CHAIRPERSON: We are sitting next on Monday at 10 o'clock. If you just remain where you are. Thank 15:35 you.

THE INQUIRY WAS THEN ADJOURNED UNTIL MONDAY, 10TH JUNE 2024 AT 10 A.M.