MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 26TH JUNE 2024 - DAY 98

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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1 THE INQUIRY RESUMED ON WEDNESDAY, 26TH JUNE 2024 AS
2 FOLLOWS:
3
4 CHAIRPERSON: Good morning everyone. Right,
5 Mr. McEvoy. 09:51
6 MR. McEVOY: Good morning, Chair. Morning, Panel.
7 This morning the Inquiry will hear evidence from Barry
8 Mills. There is a preliminary issue to be dealt with
9 in the normal way, which is in relation to the question
10 of restriction. 09:51
11 CHAIRPERSON: Okay. So I'll make a temporary
12 Restriction Order covering this application so that the
13 order is effective, if I make it. So obviously the
14 feed is cut. Yes.
15 09:51
16 RESTRICTED SESSION
17
18 OPEN SESSION
19
20 MR. BARRY MILLS, HAVING BEEN SWORN, WAS EXAMINED BY 09:56
21 MR. McEVOY AS FOLLOWS:
22
23 CHAIRPERSON: Mr. Mills, can I welcome you to the
24 Inquiry. We haven't met before, I don't think, but
25 thank you very much for your statement and for giving 09:56
26 up your morning at least to be with us. If you need a
27 break -- we will take a natural break at around
28 11:15/11:30.
29 A. Okay.

1 CHAIRPERSON: But if you need a break at any stage,
2 just give me the signal, as it were, and we'll take a
3 break. All right.
4 A. Okay. Thank you.
5 CHAIRPERSON: I'll hand you over to Mr. McEvoy. 09:56
6 MR. McEVOY: Thank you, Chair.
7 1 Q. Good morning, Mr. Mills.
8 A. Morning.
9 2 Q. You and I met briefly.
10 A. Yes. 09:56
11 3 Q. As you know, my name is Mark McEvoy and I'm one of the
12 Inquiry counsel. I'm going to take you through your
13 evidence this morning. Can I begin by directing you to
14 the folder which is just under your hands right in
15 front of you? 09:56
16 A. Yes.
17 4 Q. That contains a statement in your name dated 4th June
18 2024. It's 59 pages in length, which includes two
19 brief exhibits. Can I ask you first of all are you
20 content to adopt that statement as your evidence to the 09:57
21 Inquiry, the basis of your evidence to the Inquiry?
22 A. I am, yes.
23 5 Q. Okay. Additionally I see you've brought in some notes,
24 is that right?
25 A. Yes. 09:57
26 6 Q. Okay. Can you just tell us what those are?
27 A. It's just a few names if I needed them.
28 7 Q. All right.
29 A. For any reason. I don't think I intend on it. It

1 just depends on your line of questioning or any
2 clarification.
3 CHAIRPERSON: That's fine.
4 MR. McEVOY: That's fine.
5 CHAIRPERSON: Any notes you've got, are they made by 09:57
6 you without assistance from lawyers or anybody else?
7 A. Yes.
8 CHAIRPERSON: Fine. Thank you.
9 8 Q. MR. McEVOY: And of course it has been explained to
10 you, hasn't it, that we're using ciphers, and if you 09:57
11 need to refer to a name that you have regard to the
12 cipher list, if necessary.
13 A. Yeah.
14 9 Q. All right. Well, we can begin then. Mr. Mills, you
15 have a long career working at Muckamore Abbey Hospital, 09:57
16 and in your statement, indeed, you begin by telling us
17 something about that. You lived close to Muckamore?
18 A. I did indeed, yeah.
19 10 Q. And you had a lot of personal experience of it as a
20 child growing up as well. 09:58
21 A. Yes.
22 11 Q. Going to social functions and things I think you tell
23 us?
24 A. Yes.
25 12 Q. And you volunteered there then before you became a 09:58
26 member of staff?
27 A. I did.
28 13 Q. At paragraph 6 I think, yep, you tell us that in
29 addition to you there were some family connections with

1 the hospital as well?
2 A. There was, yes.
3 14 Q. Your mother had worked as a cleaner in the '70s?
4 A. Yes.
5 15 Q. Your brother had trained as a registered learning 09:58
6 disability nurse there, but only worked for a short
7 time in the 1980s. Other relatives you have described
8 as well, such as your niece, who did training
9 placements?
10 A. Mhm-mhm. 09:58
11 16 Q. And then your daughter worked there as a health care
12 support worker for a short period of time, before
13 moving into the community. Your son was a day care
14 worker on a permanent basis, and you also describe a
15 cousin who worked there for a while. You say you never 09:59
16 managed or worked along with any of them, and your
17 father also worked there for about six months in 1989
18 as a health care support worker?
19 A. Yes.
20 17 Q. Had you any involvement in any of those people getting 09:59
21 roles or jobs within Muckamore?
22 A. None at all, no.
23 18 Q. Now, before we move into the period which is of
24 interest to the Inquiry, which is the Terms of
25 Reference from about 1999 onwards, it might be helpful 09:59
26 if you can, just from memory, turning to paragraphs 14
27 to 16, you talk about moving through the ranks. So in
28 1991 you qualified as a Staff Nurse, and then -- as a
29 Grade D, and then in 1992 you moved to Fintona North as

1 a Grade E Staff Nurse. In 1995 you became a temporary
2 charge nurse, and then I think then in 17 you go on and
3 say that you obtained a permanent charge nurse post in
4 Fennor. Can you just help us understand the old
5 hierarchy, those of us who are lay people, the nursing 10:00
6 hierarchy under the old grading system and how it
7 worked?
8 A. Well, that was your banding. That was -- the banding
9 would have been, at that stage, would have been -- a G
10 Grade would have been the Ward Manager, charge nurse 10:00
11 level. Nursing assistant, health care worker, and I'm
12 probably digressing a bit from the start, it was sort
13 of -- were A Grades. We had enrolled nurses as C
14 Grade, and some at D Grade level as well, enrolled
15 nurses that maybe would have been taking charge on a 10:00
16 regular basis. E Grade would have been Senior Staff
17 Nurse, and then we had F Grades which would have been
18 Night Charge Nurse, Ward Sister level, and during the
19 day would have been Deputy Ward Sisters, but very few
20 Deputy Ward Sisters or Charge Nurses at that period, it 10:01
21 would have been your single G Grade Ward Charge Nurse
22 and Ward Sister. And then we went to H Grade, which
23 would have been into a senior level within the day care
24 services maybe at that stage, and then we had the I
25 Grades, which would have been the Senior Nurse 10:01
26 Managers.
27 CHAIRPERSON: So there's broadly equivalent to the
28 modern grades from 5 up to around 8.
29 A. Yeah, 8A, B. Yeah.

1 CHAIRPERSON: Yeah.
2 MR. McEVOY: So in 1998 then, paragraph 18, you tell us
3 that you obtained a new post as the Behavioural
4 Vocational and Therapeutic Services Manager, and you've
5 helpfully attached a copy of the job specification in 10:02
6 your exhibits, and I'll not take you to it. But you
7 describe then how the role was a replacement to the day
8 care services manager and was created as part of a
9 review which was ongoing into the vocational and
10 behavioural services at the hospital, and that was your 10:02
11 first step into senior management.
12 A. Yes.
13 19 Q. When you took up the post, the focus was to provide a
14 comprehensive vocational, therapeutic and behavioural
15 service within the hospital. It was a role that 10:02
16 changed over time, but you initially managed day
17 services staff and the behavioural team, which was a
18 team of nurses.
19 Prior to obtaining that post, had you any training or
20 experience in behavioural, vocational and therapeutic 10:02
21 services?
22 A. None, other than my experience during my training
23 within the day care services. I would have had worked
24 in both complex behavioural or challenging behavioural
25 wards, such as Movilla A, Fintona North and -- Movilla 10:03
26 A, Fintona North, and Movilla B, at that time, as well
27 as Moylena. I had worked closely with the
28 psychologists in the hospital at that time and the
29 behavioural team. Training, no, I had no additional

1 behavioural training as such, but just really my
2 management skills that I had from the other wards.
3 20 Q. Practical experience.
4 A. I had developed --
5 21 Q. Sorry. 10:03
6 A. Sorry, I had developed an out-of-hours type of day
7 service in Fennor Ward that I had worked in. That was
8 of great value to me, bringing a number of volunteers
9 and social care staff into work with the patients in
10 that particular ward, that would have been classed now 10:03
11 as a resettlement ward. I developed that, and some
12 sort of vocational and pastoral care within that ward,
13 that I found was good when I transferred into that
14 senior post. And I based one of the behavioural nurses
15 in that Fennor Ward. I say I based it, I requested it 10:04
16 through the senior manager at that time to have one
17 within that ward to work with it, and day care staff as
18 well, to work with evenings and weekends in that
19 particular ward, that I was the charge nurse before I
20 moved over into the clinical and therapeutic services. 10:04
21 22 Q. Okay. So effectively your background in those areas
22 was based on practical experience as opposed to formal
23 training as such?
24 A. Yes. Yes.
25 23 Q. Okay. So in paragraph 19 through to 21 then, you 10:04
26 describe day care services. You talk about how it
27 provided work skills training for low dependency
28 patients. They participated in work experience at
29 local factories, recycling plants, and some worked for

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1 the local counsel. This was in addition to placements
2 for patients within hotel services, portering and
3 catering within the hospital. There was an educational
4 programme and you worked closely with Belfast
5 Metropolitan College and the Northern Regional College 10:05
6 at Antrim. There were a wide range of certified adult
7 learning programmes for those patients.
8
9 "This enhanced the patient experience and we were all
10 very proud of this service." 10:05
11
12 You say that your role was to manage two deputy
13 managers for the day care services, the senior day care
14 workers, and day care workers.
15 10:05
16 "There were approximately 28 day care workers and 16
17 health care support workers. They provided day care
18 services throughout the whole of the hospital during
19 the weekends, nine to five."
20 10:05
21 You describe a satellite building attached to the
22 Rathmore and Rathmullan wards:
23
24 "This was nurse led care for patients with complex and
25 physical needs such as feeding difficulties." 10:05
26
27 A. Mhm-mhm.
28 24 Q. Okay:
29

1 "We focused on each patient and assessed their
2 individual needs so that we could coordinate and tailor
3 the day services to the patients, such as a particular
4 educational programme."
5 10:06
6 You say then that:
7
8 "At the multidisciplinary or MDT meetings we discussed
9 patients needs in relation to day care activities.
10 Some of the patients participated in the Special 10:06
11 Olympics and pool competitions throughout the UK. This
12 was outside of Monday to Friday hours..."
13
14 - which you worked. And then you say that:
15 10:06
16 "I felt the day care services were excellent as they
17 prepared patients for the community setting and
18 community day care services."
19
20 You were responsible for managing the entertainment 10:06
21 services officer.
22
23 "The role was to provide a wide range of entertainment
24 within the hospital, including discos, individual
25 parties and supporting events." 10:06
26
27 And that officer organised and facilitated gala days at
28 the hospital and supported the hospital chaplains in
29 relation to church services, which were all based

1 within the recreational hall.
2
3 So in those paragraphs you've given us a very good feel
4 for the day care side of things. Can you tell us more
5 about the behavioural services staff that you 10:07
6 supervised and in particular the services that they
7 provided?
8 A. How I went and got the behavioural team, the
9 behavioural team was along with children's services and
10 adult services. When I took over, just before I took 10:07
11 over, it had been divided into adult services and
12 children, so I took over the adult team, which was made
13 up of one G Grade, and two health care support workers,
14 and two staff nurses Grade E. That developed over the
15 years to having 2 G Grades and 4 E Grades and no 10:07
16 healthcare support workers within that. So that was
17 just the trained staff in it.
18 25 Q. Those staff were focused on behavioural?
19 A. Behavioural only.
20 26 Q. Yes. 10:08
21 A. And behavioural referrals. And they worked in certain
22 wards. The difficulty --
23 27 Q. Just pausing there.
24 A. Sorry.
25 28 Q. Can you remember what wards? 10:08
26 A. They worked throughout the hospital. Mostly in the --
27 in the early stages it would have been the admission
28 units, Movilla A and B, Fintona North and South. They
29 would have worked also in some of the resettlement

1 wards, but not all of them. It would have been
2 Oldstone, which was a housing development there, should
3 have been a steppingstone to the community.
4 29 Q. Yeah.
5 A. Them patients. And Fennor -- no, not Fennor. 10:08
6 Fairview, I think Fairview, that was the focus of the
7 wards at that time. Moylena. Fairview and Moylena.
8 30 Q. Okay. And how many patients would they have provided
9 services to then across those wards, roughly?
10 A. Their caseload would have been approximately average 18 10:09
11 to 20 at any one time. The problem being they never
12 appeared to discharge them, so then gradually as the
13 years went on they would have been having a caseload of
14 maybe 30/40, but they were only actively working with
15 18 to 20. 10:09
16 31 Q. Okay.
17 A. So until the patient was actually discharged from the
18 hospital, they kept them on the same workload. They
19 worked very closely with psychology, and eventually, I
20 think just before I, my role changed at one point, they 10:09
21 transferred under the Psychology Department.
22 32 Q. All right. And can you tell us what kind of training,
23 if you can recall what kind of training those staff
24 might have had in relation to behavioural services?
25 A. I can't remember. I can't remember. Tizard. I can't 10:09
26 remember just off the top of my head. The 2 G Grades
27 were trained in Canterbury, I think it was, and Tizard
28 behavioural course that was set up. I didn't
29 commission it. It was set up prior to me. But they

1 were trained in there. And I think there was one other
2 staff member in the hospital, but wasn't behavioural
3 team was trained in that.
4 33 Q. Okay. Thank you. At 22 then you describe, at the
5 bottom of page 5 you describe how your role changed in 10:10
6 September 2001 when you were given the responsibility
7 for the admission wards. Initially you describe how
8 you were given responsibility for the senior management
9 of Fintona North and South, but as we came closer to
10 moving into the core hospital you took over 10:10
11 responsibility for Movilla A, B, and Mallow Wards?
12 A. Mhm-mhm.
13 34 Q. And you were involved in the design of the new core
14 hospital and were part of the planning and design team.
15 This included Cranfield Men, Cranfield Women, the PICU 10:10
16 and Six Mile Forensic Wards.
17
18 One of your focuses, you say, was on development of
19 self-advocacy and focus groups within the hospital. A
20 lot of your work was around development in the hospital 10:11
21 and you set up a patient focus group of ex and current
22 patients. It was facilitated externally and supported
23 by a man called Paddy Rodgers, who worked a lot with
24 self-advocacy services within Northern Ireland and
25 worked on various design groups. 10:11
26
27 "The initial design of Cranfield or the PICU Ward did
28 not include a seclusion room. However, this was
29 amended after an outcome of one of the patient groups.

1 Patients felt they wanted alone time to chill. The
2 patients were concerned at moving to individual rooms
3 as they had been used dormitories. They struggled with
4 the concept of individual rooms and wanted low stimuli
5 rooms. The new hospital was all single rooms with 10:11
6 their own keys to lock the doors. The design of the
7 initial seclusion room consisted of two rooms, one with
8 toilet, sink and shower, and the other a low stimuli
9 room. This was focused around what patients
10 requested." 10:12
11
12 Just so we're clear, are you saying that residents
13 wanted a seclusion room to chill out in?
14 A. Yes. And that had come -- because there was a number
15 of events that I had arranged for the patient group to 10:12
16 attend, along with Paddy at that time, and there had
17 been a lot of work done, I believe, in mental health
18 units in England. There was a person, a spokesperson
19 was there. An ex patient from a mental health unit had
20 talked to the group about the lack of personal spaces 10:12
21 and a timeout room that they associated with the older
22 type seclusion rooms in it, that would have been in the
23 hospital, and a number of the group said that they
24 liked to get away and ventilate their feelings, whether
25 that was to shout, or some of them talked about 10:13
26 destructive behaviour that they talked about, and they
27 seen these rooms -- unfortunately at that time they
28 seen the rooms that they were going to in Cranfield, if
29 they were going to be admitted, they were going to be

1 there for a long time, almost like their home. So they
2 were quite insistent that they wanted this room.
3 35 Q. So were they using the terminology "seclusion room" to
4 mean something different? Because one would expect
5 that, certainly in terms of the evidence that the 10:13
6 Inquiry has heard, a seclusion room as a place that you
7 could be taken to against your will and you could stay
8 there for a long time, even if you wanted to come out.
9 Do you think the patients understood that?
10 A. Yeah, they were seeing it too as a room where they just 10:13
11 go where, should be bear walls and a bed in it that
12 they could just sat and would be quiet. But they also
13 felt that, they felt -- that group of people felt that
14 the seclusion room they needed that.
15 36 Q. Yeah. 10:14
16 A. They wanted that, rather than the use of medication, or
17 physical restraint, and that was coming through in some
18 of the minutes of their meetings. We had looked -- the
19 medical team and ourselves were very keen not to have
20 seclusion, because that was really -- it seemed to be 10:14
21 going out altogether, and we'd liked to have tried
22 alternative methods, but they were quite adamant that,
23 no, they wanted this room. It was difficult to
24 determine exactly was it to be a locked room, was it to
25 be -- I thought initially it was to be a multi-sensory 10:14
26 room.
27 37 Q. Yes.
28 A. And that's why I took them to see a number of
29 multi-sensory areas that we had in the hospital, and

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1 they were quite adamant, no, that that wasn't what they
2 were looking for.
3 38 Q. Is what they're describing and what you've conveyed
4 there not more akin to a low stimuli room?
5 A. Yeah. 10:14
6 39 Q. Yeah. And you've described toilet, sink, shower. No
7 other furnishings?
8 A. Yeah. Bed. They didn't want it padded. They were
9 quite adamant that that wasn't in it. Somewhere with a
10 view. 10:15
11 40 Q. Right.
12 A. And fresh air. And it was initially designed that they
13 were to be looking out into a garden area in it. The
14 problem was at the time that they didn't feel that the
15 -- the design team didn't feel that they could build a 10:15
16 robust enough en suite, so the bathroom and shower area
17 was actually as you came out of the area.
18 41 Q. Yeah.
19 DR. MAXWELL: Can I just ask about that, because the
20 words word "seclusion" has different meanings to 10:15
21 different people, you know. Another word might be a
22 "time out" space. When it was included, was it clear
23 to all the staff that this was not a seclusion room, in
24 the sense that it was a place that people were put
25 against their will for their own benefit, that this was 10:16
26 actually a time out room and that patients would at all
27 times be able to say "I'm going to leave now"?
28 A. Not to the staff. But the patients themselves didn't
29 refer to it necessarily. We were trying to press it

1 towards sort of -- it was all -- these were ex patients
2 and current patients in the hospital, and they were
3 referring to the seclusion room that they would have
4 known and they always used the term "seclusion".
5 DR. MAXWELL: Okay. So I understand that, you know, 10:16
6 they used that term, but it sounds from what you were
7 saying was they envisaged this as a voluntary room.
8 A. Yes.
9 DR. MAXWELL: They would choose to go there, and
10 presumably would choose to leave at the point at which 10:16
11 they felt they no longer needed it.
12 A. Yes.
13 DR. MAXWELL: At some point in time this room started
14 to be used for involuntary seclusion. So the question
15 I'm asking is, when it was being designed was it 10:16
16 explicit that this would always be a room for voluntary
17 seclusion?
18 A. Yeah, and it was, and it was very much part of it,
19 because I can't remember when the first actual
20 seclusion was in it, but certainly the low stimuli 10:17
21 room, seclusion room, and PICU, we had very few
22 admissions into it when it initially opened, and we
23 were in it some time before it was used for seclusion.
24 So during the staff inductions for the new units, it
25 was over a week, maybe two weeks of induction before 10:17
26 the units actually opened. There was a whole section
27 on the use of the low stimuli room, because remember a
28 lot of the admissions that were going to be coming in
29 were coming into Cranfield 1 and 2, which had no

1 seclusion room or low stimuli room. So that would have
2 been a new thing entirely from coming into the old
3 Fintona and Movillas.
4 PROFESSOR MURPHY: Did they not have single bedrooms
5 though in the new -- 10:17
6 A. They had single bedrooms rooms in the new units, yeah.
7 PROFESSOR MURPHY: So I'm struggling to quite
8 understand why they wanted a low stimulus room when
9 actually they could be using their bedroom?
10 A. Because they felt that they would destroy their 10:18
11 bedrooms. That was the patient group has said they
12 would destroy their bedrooms at the times they needed
13 -- I posed that question to them on a number of
14 occasions, you know, you can have your room, you can
15 have very little -- we didn't want furniture and that 10:18
16 many personal items. The whole aim of opening the new
17 units is that you're going to be there for a short
18 time, the community teams will be coming with you, and
19 you'd move out for a short period, but that didn't
20 happen. But it was about them actually -- 10:18
21 PROFESSOR MURPHY: So they were worried they would
22 destroy their own possessions?
23 A. Personal. Yes.
24 CHAIRPERSON: Finally can I ask, if a patient chose to
25 use the seclusion room, effectively to calm down or for 10:18
26 whatever reason, first of all, could they leave if they
27 wanted to?
28 A. If it was unlocked, yeah. They could, yeah.
29 CHAIRPERSON: And during the period that they were in

1 the seclusion room for that reason, were they under
2 observation?
3 A. It wouldn't have been recorded in it. So they would
4 have been -- in PICU it just was off the main day space
5 there, so there should have been a staff presence about 10:19
6 in it. But when someone was showing them -- sort of
7 raising concerns like that that they needed a bit of
8 time out, I would have expected staff to have been in
9 that vicinity checking regularly. It was -- from an
10 open day space, if you visited PICU, it just went 10:19
11 straight out into that area and it should have been
12 easily observed, and staff should have been regularly
13 checking, particularly in that area.
14 CHAIRPERSON: I mean there's a danger, isn't there,
15 when you're using a seclusion room for this sort of 10:19
16 purpose, that there might be a rather fuzzy boundary
17 between a member of staff saying 'Well, look, X, you
18 might want to calm down a bit, so we'll take you to the
19 seclusion room', did that happen?
20 A. I'm sure it could have happened, yeah. And I would 10:19
21 have had concerns if someone would have been, say for
22 instance sitting at the door of an unlocked seclusion
23 room in it. It would have been a question I would have
24 posed quite regularly: what was the purpose of the
25 staff sitting there? Is it to keep the person from 10:20
26 coming out? Is it observing, what you're observing,
27 how are you recording it? And certainly if a door was
28 closed I would have checked it to make sure that it
29 wasn't locked so that they could have come and go as

1 they felt like it. But the -- initially when it
2 opened, the door from the main day space into the low
3 stimuli room/seclusion room, it would have been kept
4 open quite often, where patients could have walked into
5 it. But it wasn't used an awful lot in the first year 10:20
6 or two.
7 CHAIRPERSON: But one of those events has to be
8 recorded and the other doesn't, is that right?
9 A. Yes, seclusion has to be recorded. But I would be
10 expecting someone to say if Patient A went to or 10:20
11 required to go to the low stimuli room at their own
12 request, I would expect that to be recorded.
13 CHAIRPERSON: It would be in the patient notes.
14 A. Yeah. Yeah.
15 CHAIRPERSON: Okay. 10:21
16 DR. MAXWELL: Can I just ask then, sorry. So it was
17 originally intended to be a voluntary space that
18 patients could go, with low stimulus, where they
19 couldn't damage their own property.
20 A. Mhm-mhm. 10:21
21 DR. MAXWELL: And that was understood, and that was the
22 message that was given to staff. At a point in time it
23 started being used for involuntary seclusion.
24 A. Mhm-mhm.
25 DR. MAXWELL: When was that? 10:21
26 A. I can't give an exact date for that. I'm just basing
27 it that I knew the numbers were -- I think it was at
28 least a few years when we were into -- a couple of
29 years maybe.

1 DR. MAXWELL: And did that go through a formal process
2 of having a policy and making a policy decision?
3 A. The policy was there. From when we opened there was a
4 policy on seclusion.
5 DR. MAXWELL: But there wasn't supposed to be a 10:22
6 seclusion ward, so how would that have worked?
7 A. No on the -- on PICU there was always to be the
8 seclusion, low stimuli room.
9 DR. MAXWELL: Sorry, say that again?
10 A. Seclusion or low stimuli room, it was always to be the 10:22
11 two options there, you had the -- it was to be -- there
12 was a policy for use of seclusion if it was required or
13 it to be used for low stimuli.
14 DR. MAXWELL: So right from the beginning the policy
15 did allow it. So it wasn't set up to be only 10:22
16 voluntary?
17 A. No.
18 DR. MAXWELL: It was set up to be used for both from
19 the very beginning.
20 A. No. Both. Yes. Mhm-mhm. 10:22
21 DR. MAXWELL: Okay. Thank you.
22 CHAIRPERSON: Thank you.
23 42 Q. MR. McEVOY: Just to finish this point about the
24 seclusion. We'll come back to the remainder of 24 in a
25 moment, but at the end of paragraph 24 you say: 10:22
26
27 "The seclusion room did not at that stage open into a
28 garden and did not have an en suite bathroom as we did
29 not strong enough materials."

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1
2 I think that's something you touched on a moment ago.
3
4 "Patients had to leave seclusion to use the toilet.
5 This was not the best of designs." 10:23
6
7 So presumably even if they were in the seclusion room
8 on a non-voluntary basis and they needed a toilet, they
9 would have had to leave it.
10 A. Yes. Yeah. 10:23
11 43 Q. Okay. Just going back then to the remainder of 24, and
12 there you talk about, again, the meetings with
13 Mr. Rodgers with the patient groups. These patient
14 groups, just to clear this point up, that you have
15 described, and discussion with them, are these patients 10:23
16 groups focusing on design?
17 A. Mhm-mhm.
18 44 Q. Were there patient groups for any other purpose, or did
19 indeed those patient groups have any other items within
20 their remit, if I can put it that way? 10:23
21 A. No, not that group. No, that was just purely around
22 the design of the new build.
23 45 Q. Were there other similar patient advocacy groups?
24 A. No, not really at that stage, no.
25 46 Q. Okay. In 24 then you mention in addition to seclusion 10:23
26 as a controversial item, also the question of
27 installation of CCTV. Here you say then about halfway
28 through the paragraph:
29

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1 "Professionals on the design team felt we needed to
2 move on from the use of seclusion room using more
3 therapeutic methods. The professionals and focus group
4 felt CCTV made patients paranoid and this is why it
5 didn't go into the opening of Six Mile and PICU." 10:24
6
7 But then you go on and say you felt differently as you
8 worked with the Public Protection Unit within the
9 police service.
10 10:24
11 "Every time an allegation..."
12
13 - you say:
14
15 "...against a patient or staff occurred..." 10:24
16
17 - you believe it would have been made much simpler if
18 CCTV was installed and that it would have improved the
19 investigation.
20 10:24
21 What date was that discussion? Approximately around
22 what year would that discussion around CCTV have taken
23 place?
24 A. 2004 maybe. It would have been around then. Two, to
25 four maybe. 10:25
26 47 Q. And --
27 A. It was in the -- well the units opened in 2008. So it
28 would have been around 2004 when that -- 2003/04,
29 around that.

1 48 Q. Okay. So there was discussion around CCTV at that
2 stage?
3 A. Was with me, yeah.
4 49 Q. Yeah. And decision then as we know presumably was
5 taken not to install it at that time? 10:25
6 A. Yes.
7 50 Q. Do you know where that decision would have been taken
8 or by whom?
9 A. The design team would have been -- it should be in the
10 minutes of the design team meetings. 10:25
11 51 Q. Okay. And do you know after it left the design team
12 whether the issue was discussed at any other level,
13 potentially within the Trust level?
14 A. I don't know. I don't know, no.
15 DR. MAXWELL: But the decision would have been taken 10:25
16 when it was North West Belfast HSST presumably?
17 A. Yeah.
18 DR. MAXWELL: So it was before the Belfast Trust came
19 into existence.
20 A. Yeah. 10:25
21 52 Q. MR. McEVOY: And that happened in 2008 when the
22 creation of the new Trust took place?
23 A. Mhm-mhm.
24 53 Q. An effect of that was that you had to re-apply for your
25 posts? 10:26
26 A. Mhm-mhm.
27 54 Q. And you applied and were successful in appointment as
28 the Clinical and Therapeutic Services Manager within
29 the hospital. It was the same job description and you

1 held the same responsibilities over admission, forensic
2 and day care services, and to assist you've also
3 helpfully exhibited that description to your statement.
4 Your new post covered forensic services?
5 A. Mhm-mhm. 10:26
6 55 Q. That was a new ingredient?
7 A. Yeah, it was, yeah. It was a new unit and it was a low
8 secure unit. It was -- I had known the patients from
9 their admissions in it, but it was new to us, yeah.
10 56 Q. What experience or training had you had in the forensic 10:26
11 aspect of Learning Disability Services?
12 A. None.
13 57 Q. Were you offered any on appointment? Was the question
14 of getting some training discussed with you?
15 A. No. 10:27
16 58 Q. Okay. And then you go on and describe how in 2008
17 there was a new co-director, Mrs. Somerville,
18 appointed. You wanted to establish a self-advocacy
19 group at the hospital. She had a number of connections
20 that could help with this. You go on to describe 10:27
21 those, including the association for real change, or
22 ARC, who came in as a lead in:
23
24 "In 2008 we set up the "Tell It Like It is" group to
25 give patients a voice. It was uncomfortable for 10:27
26 patients at the start."
27
28 You say:
29

1 "All patients had a vote to elect the group. There was
2 a strong voice in the hospital who met with the
3 management team, to include the service manager,
4 medical lead, social worker lead, and co- directors."
5 10:28
6 You describe each patient voting as to who they wanted
7 to represent them on the group.
8
9 "Brought up a number of issues and they were involved
10 with recruitment of advocacy services being set up 10:28
11 within the hospital."
12
13 You felt they were a strong group and were involved in
14 the staff induction training. Spoke about their
15 overall experiences in the hospital. You liked the 10:28
16 idea from the start, and as you became more involved
17 you saw its impact on services and patients. Your role
18 in relation to the TILII Group remained the same, but
19 in 2012 the Service Manager and co-director retired and
20 a new co-director was appointed, and that was H507. 10:28
21
22 In 2013 you go on to tell us one of the decisions that
23 Muckamore management team made was that you would be
24 the link to the TILII Group. You would you relay
25 information between it and the management team. You 10:28
26 didn't think it was a good idea, but you agreed with
27 the TILII Group that if there were any serious issues
28 you would go to the hospital management team. You feel
29 that the TILLI Group no longer had the same influence

1 on services.
2 What changes -- can you give us some examples of the
3 changes that the TILII or "Tell It Like It Is" Group
4 achieved?
5 A. Well certainly in relation to -- from catering, food, 10:29
6 choice of food, transport in the hospital, the access
7 to transport, the patients getting more access to
8 taxis. Having their named nurses, the changing of
9 staff throughout the hospital, the named nurse of a
10 patient that was ready for discharge had come to us and 10:29
11 couldn't be moved. They had specifically requested
12 that on behalf of a number of patients that were maybe
13 moving -- we had to maybe move staff around for one
14 reason for another. The paths in the hospital, disable
15 access in some of the areas. Improvements in the 10:30
16 laundry system. I think the biggest impact I think was
17 them actually -- they had a session to speak at new
18 staff induction.
19 59 Q. Mhm-mhm.
20 A. And their experiences of being how they were spoken to 10:30
21 by staff, how they could be more involved in their
22 medication, the decisions on medication.
23 60 Q. Was that induction of all staff?
24 A. Mhm-mhm. Well they were up until -- from about 2009
25 they would have been involved in it. They also came 10:30
26 out and gave staff, training to staff that were
27 currently working in the hospital and maybe hadn't
28 availed of it. They talked about their experiences of
29 how they were being elected. I spoke at it too, and

1 one of the things -- I hope I'm not going off on a
2 tangent, but actually when we first decided or got the
3 go ahead to go with the patient council, or TILII
4 Group, it was always to be an election. We had a
5 number of staff in the hospital, fairly senior, both 10:31
6 nursing and medical, that it would be better that they
7 would refer a patient to be named on the council as
8 opposed to an election, because it may affect someone
9 maybe in active treatment, they thought that this maybe
10 would have had an effect on their treatment, or their 10:31
11 time in the hospital may be extended, they may be too
12 anxious to be involved in the TILII Group. But they
13 said how positive it was being elected in it and they
14 felt that it was a vital role. They felt it useful
15 going to the hospital management meetings, even though 10:31
16 they were taking issues from that, the management team
17 shared some concerns with them and asked them what they
18 thought about should it be actually buildings
19 themselves what they thought about it, and a number of
20 things they raised, and whenever -- about the new 10:32
21 buildings being too warm, and that was an issue, a big
22 issue with them. But the hospital management team at
23 that time, I felt, got a lot from the actual patient
24 group itself.
25 61 Q. And you have said that you felt it was not a good idea 10:32
26 that there was a change in the relationship. It was
27 agreed if there were any serious issues that you would
28 go to the management team and the effect you've
29 described was that the group no longer had the same

1 influence and services?
2 A. Yeah.
3 62 Q. Where did the impetus for that change in the way things
4 -- things appear, on the basis of what you've said, to
5 have been working quite positively? 10:33
6 A. Mhm-mhm.
7 63 Q. Where did the impetus to change things come from?
8 A. It come from that current hospital management team
9 really. They felt that it would be sufficient whether
10 -- they felt that they were under a lot of pressure, 10:33
11 other issues to talk about at their core hospital
12 management meeting, but I was advised by my line
13 manager -- can I name them?
14 64 Q. If you can find the cipher that would be really
15 helpful? 10:33
16 A. H507.
17 65 Q. Yep.
18 A. And she advised me that it come from --
19 CHAIRPERSON: If you write it down for the Inquiry
20 Secretary then she can probably help you. She knows 10:33
21 some of the ciphers backwards.
22 66 Q. MR. McEVOY: I think you can name that individual.
23 A. John Veitch.
24 67 Q. Yeah.
25 A. It come from that. 10:34
26 68 Q. Okay. And you said it wasn't -- you thought it wasn't
27 a good idea. Did you convey that view to management?
28 A. Yeah. Yeah, I did. The patients and the group, they
29 appeared satisfied initially on it, and I just think

1 that they lost a lot of the power that they had in the
2 service, and their -- just their presence within the
3 hospital team, and I think the management team would
4 have lost out a lot on that, because I gained -- by
5 going to it, I gained a lot of insight into the 10:34
6 difficulties. Not just with the difficulties in the
7 hospital, but the difficulties with their discharges
8 and other patients discharges, what they felt like
9 being stuck in a hospital. And I think that's really
10 what the management team lost out on. It just -- and 10:34
11 if it had of stayed, if they had of been allowed to
12 carry on -- they never made a formal, raised it
13 formally, but I think they would have heard the voices
14 of patients that were in the acute admission units, not
15 just resettlement. Because you have to remember here 10:35
16 that a lot of these people -- and I see it constantly
17 being referred to, people being resettled. Our acute
18 admissions, what were classed as acute admissions, were
19 stuck in hospital for years, and a lot of these
20 patients were low dependency, and they had come from 10:35
21 Cranfield and Six Mile and been voted on to be
22 counsellors. When they got the opportunity to see them
23 face to face and listen to some of the issues that was
24 -- they had lots a problems and issue to raise, not
25 just within the hospital, but why they were being 10:35
26 discharged and why they come to be in the position that
27 they were in.
28 69 Q. At 29 you describe your interactions with the parents
29 and friends of the hospital and society?

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1 A. Mhm-mhm.
2 70 Q. They supported resettlement wards, you say, but they
3 weren't as involved in the new core hospital. They
4 helped fund a number of initiatives, such as nurse
5 scholarships, social trips for patients, and Christmas 10:36
6 gifts. You were involved with the brother of P107 as
7 Deputy Chair?
8 A. Yes.
9 71 Q. And they were always in and out of meetings with
10 Mrs. Somerville advocating for patients on 10:36
11 resettlement. Mr. Murphy and Mr. McNally were Chair
12 and Deputy Chair of the Parents and Friends Association
13 and sat on the design team also for the new hospital.
14
15 "They were quite influential in the hospital too from 10:36
16 the early design stages until 2013."
17
18 You recall the brother of P107 saying that he was very
19 frustrated over his role within the hospital regarding
20 resettlement wards, but you had no control over 10:36
21 resettlement wards at this stage.
22
23 In terms of the role of that organisation, can you
24 describe your experience of how the role developed over
25 your time at the hospital? 10:36
26 A. Well, I suppose if I go right back, I wouldn't -- I
27 don't believe I'd even be in the position that I ever
28 come to in Muckamore, even going into learning
29 disability nursing training, if I hadn't met up with

1 the Chair at that time of the Parents and Friends, it
2 just happened to be a chance meeting with him, and
3 there were -- I think her name is maybe here, but it's
4 mentioned in my first paragraph, or the second
5 paragraph, where I had met her -- but they were very 10:37
6 actively involved in the hospital, and the development
7 of the hospital from the start, they were in and out of
8 the wards all the time raising issues constantly. But
9 I found that they were very much focused, and quite
10 rightly, on the resettlement wards, because that's 10:37
11 where the bulk of their relatives were in it, and they
12 had a strong wish -- they wanted the best for their
13 relatives. They weren't there to object to
14 resettlement, they wanted the best. And even in the
15 early days of the design, they had put a proposal 10:37
16 forward of a therapeutic community to be built on the
17 site of the hospital, and I think the Parents and
18 Friends actually commissioned or paid for a proposal to
19 be put forward on that.
20 72 Q. Can you remember when that would have been? 10:38
21 A. That would have been in the early 2000s or maybe -- it
22 must have been the early 2000s at least, before this
23 design team for the core hospital came in. But they
24 felt that a therapeutic community on the site would
25 have been the best for them, because they had 10:38
26 experience of very little community facilities for
27 their relatives, but they were very much focused on
28 resettlement. But I had involved them with the design
29 team for the development of the hospital as well. I

1 often would have been in contact with the then Chair.
2 73 Q. You can write the name down if you...
3 A. I think I might have seen it here.
4 CHAIRPERSON: They might not be in the H --
5 A. It's actually on the script. Jack Murphy and Malcolm 10:39
6 McNally.
7 74 Q. So Mr. Murphy, yeah. He's not ciphered. Yeah. So,
8 Mr. Murphy?
9 A. Yeah.
10 DR. MAXWELL: Can I just ask what you mean by a 10:39
11 therapeutic community on-site?
12 A. Almost like a village as such, they wanted to build,
13 with bungalows and houses where --
14 DR. MAXWELL: So they wanted supported living on-site
15 you mean? 10:39
16 A. Yeah. Yeah. And that included both for their
17 relatives and people in the future to come into it as
18 well.
19 DR. MAXWELL: So would that be a bit like the Oldstone
20 buildings? 10:39
21 A. Yeah. There was a place in Co. Down, it was a
22 voluntary organisation that -- I can't remember the
23 name of it now, but I think some of the families had
24 visited it. It was run by -- it was people from
25 Germany and different countries had come into it, and 10:40
26 they actually lived with families, their family coming
27 and people with learning disability lived with them,
28 and they had a farm and things like that on it.
29 DR. MAXWELL: Was it run by Larch?

1 A. Yes.
2 DR. MAXWELL: Yes.
3 A. And that sort of touched on something that they were
4 looking for, but they still were very -- they wanted to
5 keep the nursing staff that was there with them. But 10:40
6 it wasn't a hospital as such. But it didn't --
7 obviously it didn't get through onto it. But they were
8 very keen on that. But they were always involved in
9 promoting their day care services. The Chair would
10 have been involved in even commissioning some of the 10:40
11 adult training programmes. But I did notice whenever
12 we opened the units, be it my fault or whatever, they
13 still were very much focusing on resettlement, and I --
14 obviously I didn't go actively out to get them to come
15 into the wards to -- promote the Parents and Friends 10:41
16 and that, they had the leaflets and people were made
17 aware of it, but not to the extent that it would have
18 happened in Finglass, Rathmullan, Rathmore, Greenan
19 Wards, places like that, where the active resettlement
20 was going on. But they were really, to me they were a 10:41
21 brilliant organisation to support the hospital. And
22 they did make, in my early days in the '80s and that,
23 they made significant changes on the wards and would
24 have raised a number of issues with senior management
25 in the hospital at that stage. 10:41
26 75 Q. MR. McEVOY: At paragraph 30 you say that:
27
28 "Up until 2012 I had always felt no matter what role
29 they had there was ambition amongst staff and

1 management to make the hospital better. This was in
2 terms of service for patients and buildings. The
3 resettlement was still going on during this period.
4 Staff wanted to see patients in good community settings
5 and receive day care." 10:42
6
7 You say:
8
9 "It was a brilliant time to be involved in management.
10 There were staff shortages and difficult admissions but 10:42
11 still a buzz to make it better, advancing with new
12 units, but there was not the funding in the community
13 to establish good resettlement plans."
14
15 Firstly, what was it that changed in 2012? 10:42
16 A. Well, nothing really changed. The focus did move on to
17 resettlement, and at 2012 they were all like a new
18 management team as such, but I always felt that people
19 wanted to make the hospital better. It didn't matter
20 what level of management that was there, even from -- 10:42
21 if we had directors coming from the Belfast Trust, or
22 from North and West Belfast, always to make it better.
23 Even when we had very little resources, it was the
24 height of the Troubles, we still wanted to make it
25 better and give the best patient opportunity that we 10:43
26 could possibly do, with very, very limited resources,
27 very limited resources.
28
29 2012, I believe that the focus was then to push the

1 patients out, to get them out into the community
2 setting. Parents and friends were anxious because they
3 still wanted the best community placements for them,
4 and staff were beginning to be very anxious about the
5 type of units they were going to, and they didn't feel 10:43
6 at that time that certainly it was for betterment to
7 them. It seemed very similar to they were coming from
8 both the less social and community engagement in it.
9
10 But there was things that happened post 2012, and I 10:43
11 think I maybe do it say it in my statements, where one
12 of the things that was always promised to the
13 relatives, that the staff would stay with them until
14 that ward closed. And that would be their named
15 nurses, or health care support workers that knew them. 10:44
16 And what people did forget about from that, I believe
17 from 2012, the importance of other staff within these
18 wards. To run a good ward I think you need good hotel
19 services, domestic staff, maintenance staff, people
20 that know the patients. And don't try to make little 10:44
21 of our domestic staff. Sometimes they would know some
22 of our patients as well because they've been working
23 with them for years and coming in and maybe just, even
24 just with a chat. When would I have visited a ward I
25 got as much from my catering and domestic staff as I 10:44
26 did maybe from the nursing staff about someone that
27 maybe there was an issue with them. And our relatives
28 would have said that too. And they were forgot about.
29 Because when these wards were getting smaller, just one

1 day the domestic that maybe had worked with them for
2 five, six years, or worked in that unit, was gone away
3 to another unit. And it always sticks in my head, I
4 can always remember Miriam Somerville and other ones
5 saying to the relatives to give them assurances about 10:45
6 the resettlement process is that 'You will have that
7 staff until they transition to the community', but that
8 changed. When wards become -- now, in the past when a
9 ward become very small and you had maybe only about
10 five or six patients left in it, and there's another 10:45
11 ward coming down to about 10, you might have combined
12 them two wards, and I can remember the first ward that
13 I was a temporary charge nurse in was Rathmore, and the
14 way they done it with it was Clonshee Ward, would have
15 had a small group of patients that wasn't necessarily 10:45
16 compatible with the other group of patients in
17 Rathmore, so we had to work with the relatives, get the
18 relatives over to visit it, but the patients had to
19 come and visit it. And so the domestic staff come with
20 them, the catering staff come, if there was, and the 10:46
21 nursing staff come. But you had the induction, and
22 there was the one Ward Manager, and they knew the ward
23 that they were coming to, and the patients and the
24 relatives. It wasn't the best, but it still made it
25 possible to run as one ward on the one team. 10:46
26
27 After 2012 we were getting down to the small core
28 numbers of patients in one ward. And Finglass, I can
29 remember it -- is that okay? And it just went down to

1 8 or 9, and we were really under awful pressures for
2 staffing in the hospital. Right throughout the
3 hospital. And then it was decided that we would move
4 these patients to Rathmullan. And it just -- they
5 weren't necessarily compatible, but it was also anxious 10:46
6 for the relatives of the patients in Rathmullan
7 building too. So they just moved, and a core group of
8 them staff went, and I think all the staff actually
9 moved over to it, domestic staff would have went to
10 other areas of the hospital, and that was unsettling. 10:47
11 But what then happened, when then that small ward got
12 down again, they were moved to another ward, and it
13 just -- all it was -- to me, and the only way I can
14 describe it when we finally ended up, was corralling of
15 patients and staff. 10:47
16 76 Q. Yes.
17 CHAIRPERSON: What opportunities did you have to
18 reflect those concerns that you obviously had?
19 A. It was happening in front of me and I didn't get the
20 opportunity, because the resettlement wards weren't my 10:47
21 area, I was just picking it up from, you know, if you
22 would have met maybe with that relative I had mentioned
23 from Parents and Friends, they were anxious about where
24 they were going to go to next, and did I think they
25 were safe, the patients that was going into the area 10:47
26 where their loved one was? And I couldn't -- because I
27 didn't know the patients at that stage. But I was, how
28 I was picking up from it was more the staff who thought
29 that they had posts in the core hospital, the new

1 buildings that were being built, where I had temporary
2 staff working with them, that they were going to get an
3 opportunity then. My ward is closed, and they were
4 saying 'Well, Barry, why am I not going to the new
5 units?', and they were saying -- because them other 10:48
6 units were short, they were trying to say that they
7 were with their patient, but it was only a small number
8 of patients. But then people then moved round all the
9 resettlement wards that they were closing, instead of
10 coming into the core. 10:48
11 CHAIRPERSON: Sorry, Dr. Maxwell. What I'm really
12 trying to get at is, how were you able -- did you have
13 any system of escalating this?
14 A. Well I did raise it at the hospital management meetings
15 and to my line manager. 10:48
16 CHAIRPERSON: Right.
17 A. But I believe it was seen as if I was opposing
18 resettlement, trying to put a block into it. A bit
19 like the staff was raising the issues, a bit like how
20 the Parents and Friends were seen as almost at the 10:48
21 early stages as an objection to community care, which
22 they were absolutely not. They were 100% behind it, if
23 it was right for their relative, and me or you would be
24 the same. You just want -- but you have to remember
25 too that what I found with the TILII Group, and we 10:49
26 would have raised it at many of the meetings, is that a
27 lot of our patients didn't have relatives and they
28 hadn't the Parents and Friends. So the TILII Group was
29 good at that, because some of them -- and quite a lot

1 of them didn't have relatives. They were speaking up
2 for themselves. And it wasn't nice to hear some of it
3 at times, but it was worth listening to.
4 PROFESSOR MURPHY: It was obviously difficult -- sorry.
5 DR. MAXWELL: Can I just ask, did you say earlier that 10:49
6 some patients were moving from one ward and then that
7 ward closed and they were moving to another?
8 A. Yeah.
9 DR. MAXWELL: So they had multiple changes of wards.
10 A. Absolutely, yeah. 10:49
11 DR. MAXWELL: And over what sort of time frame would a
12 patient move multiple times?
13 A. I'm trying to think. Probably from 2012 we had -- they
14 could have moved at least three times until at least
15 2016. 10:50
16 DR. MAXWELL: Really?
17 A. And you have to remember too that that was -- staff
18 were moving with that.
19 DR. MAXWELL: Yes.
20 A. And they were fairly short -- there was plans for it, 10:50
21 but they were at fairly short notice. When Oldstone
22 closed -- Oldstone was so -- it was brilliant. It was
23 absolutely brilliant, particularly for us in the core
24 hospital when we were overcrowded, we had people who
25 were low dependency -- it wasn't the best of buildings, 10:50
26 but it was a house, and it was a step out heading in
27 the right direction, and at least they have a kitchen
28 and a place to have -- you were sharing it with other
29 people, but I thought it was a great step down. And I

1 would have been perceived as advocating on behalf of
2 Oldstone all the time, I never managed it, but I just
3 seen it as a good unit for people stepping out of
4 hospital. If you were stuck in hospital, it just -- I
5 can't describe just what it's like. Stuck in hospital 10:51
6 in a resettlement ward, yeah, it was difficult, but
7 that was your home for a long time, and you were with
8 people that you knew. But to get stuck in an acute
9 ward with people coming in that may have been unwell,
10 and ones that may be not too unwell, and living in one 10:51
11 room. And I mean at the same time we were reducing
12 staff numbers, we were reducing our day care services,
13 really important things to these people, not important
14 in an acute hospital where the aim was to have people
15 being admitted for six weeks, their community team 10:51
16 following them in and following them out, it just
17 didn't happen. And you had staff so frustrated. They
18 wanted to stay with their patients, and don't get me
19 wrong, and I'm sure some of them would challenge me,
20 because they did want to go with them, and I think that 10:52
21 if -- actually I could -- there was a few Staff Nurses
22 I think it was detrimental to their career, because
23 they could have went up the ladder, but they stayed
24 with them patients and moved with them, and that was
25 hard. And I would have loved to have had them in the 10:52
26 core hospital.
27
28 In the meantime in the core hospital I was running
29 people temporary for four years who could easily have

1 been in the first year, if that first closure had of
2 happened and they all went out then, them staff would
3 have replaced the temporary staff. But it ended up
4 with such a mix of patients. And I don't believe they
5 were the right buildings either. There was no 10:52
6 investment into these buildings. And you have other
7 areas where, and I'm sure we'll come to it when we talk
8 about these pods or apartments. I really was focusing
9 -- I had a lot of concerns about admissions that were
10 coming into Cranfield and to Six Mile, that was going 10:52
11 on too, and I was running with staff shortages as well,
12 rather than to focus on it. But it did appear on the
13 outside that resettlement was working. You know a ward
14 closed, but I don't think whether the Department or
15 Health or that realised the impact on that. Three or 10:53
16 four or eight, does it matter? But if it affects one
17 person, it affects two or three staff to go with them.
18 CHAIRPERSON: Okay.
19 A. That's as much important to me. Well it is important
20 to me, I think it is. You just don't move people 10:53
21 around like cattle.
22 PROFESSOR MURPHY: How would you have done it had you
23 had the power to do it yourself? Because obviously its
24 difficult if you're moving such a large number of
25 people out in resettlement. 10:53
26 A. I would have done it the way Miriam Somerville had
27 said, and given the assurances to the relatives. I
28 would have -- focused on the one ward, and when that
29 last patient walked out of that ward that was the

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1 closure of that ward.
2 PROFESSOR MURPHY: Yeah.
3 A. And it didn't -- it's not that difficult. They weren't
4 going to supported living. I mean most of them they
5 were going to either, whether it was nursing homes, but 10:54
6 they were going to areas close to maybe where their
7 family was, it could be in the Northern Trust, it could
8 be in the Southern Trust, or the South Eastern Trust.
9 PROFESSOR MURPHY: So do you think the reason they
10 didn't do it like that was really financial? 10:54
11 A. Absolutely. Financial and the sheer -- the resources
12 that we had in the hospital, we weren't recruiting.
13 PROFESSOR MURPHY: Yes.
14 A. And we had temporary in it. I was told Finglass that
15 maybe only one trained staff on a shift and it was made 10:54
16 up of health care support workers. But the plan
17 discharge was not to go to a nursing home or it wasn't
18 -- they didn't need specialised nursing in it. But I
19 think for -- there's two patients, or there's two sides
20 that's affected by this; the patients in the ward that 10:54
21 they're moving to and the patients that are moving, and
22 it's just not a matter of closing a ward down one day
23 and open up. You've two teams and that team -- and I
24 think the team that moves into the other ward felt that
25 they were always second best, they were in the other 10:55
26 team, because they maybe didn't go with the Ward
27 Manager. And I keep saying that the importance of all
28 the auxiliary staff, all the staff in it, from our
29 cleaners right through. The voluntary services maybe

1 would have changed differently as well, the activities
2 that would have been based around that ward would
3 change to suit the other ward as well. So I believe
4 that -- financially it may not have been possible --
5 but I'm sure there should have been a lot more thought 10:55
6 went into it.
7 PROFESSOR MURPHY: Thank you.
8 77 Q. MR. McEVOY: We're going to come back to the situation
9 post 2012 in one moment.
10 A. Okay. 10:55
11 78 Q. Before we do, there's one issue just to close off the
12 pre-2012 situation, and that is around the recreational
13 hall.
14 A. Mhm-mhm.
15 79 Q. You said: 10:55
16
17 "We made mistakes before 2012 too."
18
19 And you said the recreational hall, at paragraph 31,
20 yes, thank you. 10:55
21
22 "...served as a community centre and kept us in touch
23 with the community."
24
25 You say that: 10:56
26
27 "People might say it's an institutional thing, but it
28 was the heart of the hospital."
29

1 And you think it gave the wrong image for the new
2 hospital. But people from the local community came to
3 the hospital for walks in the grounds, used the pool,
4 voluntary groups used the recreational hall, and the
5 patients lost out when it was closed. And if you had 10:56
6 your way you would have got rid of the administration
7 building?
8 A. Absolutely.
9 80 Q. I think is that instead of the recreational hall?
10 A. Absolutely. 10:56
11 81 Q. The day service was between 9:00 to 5:00.
12 Entertainment provided. Evening and Saturday
13 activities for patients. And one of the mistakes was
14 knocking down the hall. You think it could have been
15 redeveloped. Do you know where the decision to knock 10:56
16 it down came from?
17 A. I think it was always -- both within North and West
18 Belfast, and in the Belfast Trust as an institutional
19 thing, you drive into it and this recreational hall,
20 and it's a big red building to the font of it. There 10:57
21 was very little consultation -- well, there was no
22 consultation done in relation to patients or staff
23 about the closure of it. Why I say it was the heart of
24 the hospital, people from Antrim and further away would
25 have used the hall for various functions, and our 10:57
26 patients used it with them. They were always part --
27 they didn't just rent out the hall and that was...
28 82 Q. Yes.
29 A. They were at it. Volunteers came at in. There were

1 shows in it.
2 83 Q. Yes.
3 A. But also it was a happy environment. They come and
4 they could mix. It was probably the predecessor to
5 TILII. They come, and the other patients, the male 10:57
6 patients and the female patients met, not as surely to
7 build up relationships and boyfriends and girlfriends
8 and that, but actually to sit and talk, and staff had a
9 great buzz in it, and it was -- it really was -- and I
10 -- you just can't capture the atmosphere that was in 10:57
11 it. And from my early days into it, when people that
12 had never worked in Muckamore Abbey talk about it, and
13 there's three buildings, not in this, in Muckamore
14 Abbey, that I felt that kept us in contact with
15 community. Not necessarily Belfast, but with the 10:58
16 Antrim community. We had our swimming pool, and we had
17 a beautiful garden horticultural department, and each
18 year we sold to the community. But the swimming pool,
19 firstly, it brought in numerous amounts of community
20 people into the units, from voluntary organisations to 10:58
21 just families who never needed Muckamore Abbey as a
22 hospital, but maybe had a child with a learning
23 disability, and they couldn't use the public baths,
24 and they -- it was many, many people came in. That was
25 the only type of activity they could do as a family. 10:58
26 They had maybe the one child with a learning disability
27 and their two brothers coming in and swimming. And the
28 amount of people that I have met in Antrim that have
29 learnt to swim in Muckamore Abbey swimming pool is

1 unreal. I don't know how they all got in to learn how
2 to swim in it, but they were there. But I'm talking
3 about people that never had to use it as a hospital for
4 treatment.
5 10:59
6 The other area -- but it brought people in to see what
7 we were doing. The other area who the Horticultural
8 Department, which I think it was after I gave up day
9 care services it was stopped public access to that
10 area, because we sold the plants every year, and people 10:59
11 came in at the weekends to water them, and patients
12 would have went then on a Sunday to do that as well.
13 But it was stopped because they thought it would be too
14 risky. We had some forensic patients in it, but they
15 were staffed, and we had done that for years. I never 10:59
16 had an incident involving a member of the public in
17 that garden. But it was too risky. And these were
18 people that were delayed discharges. They had been
19 working in it. That - - I lost that. So lots of the
20 stuff. 10:59
21
22 But going back to the recreation hall, it was just a
23 brilliant buildings, and we could have developed it,
24 and the reason why I said the recreation -- the admin
25 building, this is even as institutional looking, 11:00
26 because every time it comes onto the media for the
27 Public Inquiry, it just shows you this big red
28 building. But that -- if we had of had all the
29 managers and the doctors all out around the wards, I

1 just wonder would we be sitting here today? Based on
2 it. Because it was the first thing they done, and that
3 was part of their action plan, they decided that I --
4 I had an office in it, but most of my career I had
5 offices linked to where the day care services was, over 11:00
6 to where the behavioural service was, so you always had
7 patients coming and going, and you do see a lot of
8 stuff there, but I just wonder if that had of
9 happened...
10 CHAIRPERSON: Sorry, can I just stop you for a second 11:00
11 because I think you -- maybe it's just me, but you
12 mixed up two concepts. You were talking about the
13 closing of the hall and the importance of the swimming
14 pool and the horticulture, but then you said:
15 11:00
16 "We had all the managers and doctors all out around the
17 ward and I just wondered if we would be sitting here if
18 that had continued."
19
20 So what's the connection between -- 11:01
21 A. I just think when you're at the coal face -- be it a
22 manager or what senior level at, if you can get on to
23 the wards --
24 MR. McEVOY: I think in ease of the witness he had
25 mentioned something about the closure of the 11:01
26 administration building.
27 CHAIRPERSON: Right.
28 DR. MAXWELL: Yes. I think you were saying they
29 weren't on the wards, they were in the administration

1 building.
2 CHAIRPERSON: Is that the connection? Sorry. Well,
3 thank you.
4 A. Yes. It's a bit like -- well I'm sure you'll pull me
5 in if I'm going off on a tangent, but some of the stuff 11:01
6 that happened within the admin building, you know, I
7 think it was around 2014/15, my office was open, just
8 you come into the admin and you could knock the door,
9 patients could come to it, and that was stopped. There
10 was an incident, one incident, and I don't know if 11:01
11 someone was injured, it was involving a patient and
12 maybe a secretarial staff, and it could have been -- it
13 may have been quite traumatic too, yeah, but it was
14 closed. The doors were locked. So they had to
15 actually go to a secretary of mine to ask to speak to 11:02
16 me. And I could see -- I would have had patients
17 coming to me, not to complain, they would have come in
18 and if there was things going on, or even if we were
19 only moving on, to say goodbye. Some of the TILII
20 Group and they would have come and had a chat with me. 11:02
21 Relatives. But other people within the hospital, staff
22 would have felt more. But -- and staff, if they had
23 something on their mind, they're not going to make an
24 appointment. And you might as well have made
25 appointments when you had to go through a secretary. 11:02
26 So I think we lost something there. Just it brings
27 management away from it, and my career as a manager,
28 even as a senior manager, was always you were either
29 based within the day care services, before that it was

1 work skills, we weren't far from it, and then it was in
2 what they called the social training centre, and that
3 was near where the behavioural team was, but the admin
4 was...
5 84 Q. MR. McEVOY: And when did you -- just on that point 11:02
6 then before we leave it, when did you move into the
7 admin building?
8 A. I think it was around -- just before 2012 I went into
9 it, I think it was.
10 85 Q. And was that -- 11:03
11 A. Before that -- just I think it was around that, just
12 around 2011/12.
13 86 Q. And with that role, and having an office in there then,
14 that meant the secretary came with that post. Is that
15 -- 11:03
16 A. Yeah.
17 87 Q. Am I correct in that understanding?
18 A. Yeah, the day care service, yeah.
19 88 Q. Yeah. Okay. We can go back --
20 CHAIRPERSON: We're coming up to a break. I'll leave 11:03
21 it to you.
22 MR. McEVOY: No, we can actually pause there. That's a
23 good point to pause, Chair, actually. That's a natural
24 break perhaps.
25 CHAIRPERSON: Okay. Okay. We normally take a break 11:03
26 around now. So we'll just take a 10 to 15-minute
27 break. You'll be offered a cup of tea and then we'll
28 come back. Thank you very much.
29

1 A SHORT ADJOURNMENT
2
3 THE INQUIRY RESUMED AFTER THE SHORT ADJOURNMENT AS
4 FOLLOWS:
5 11:20
6 CHAIRPERSON: All right. We're going to sort of carry
7 on and see how far we get. If we've got to sit a bit
8 later sort of after 1:00 o'clock, we'll try and get
9 that done. But if at any stage you are flagging, will
10 you just let me know? 11:25
11 A. I will indeed, yeah.
12 CHAIRPERSON: And we'll take a break again. Okay.
13 89 Q. MR. McEVOY: Thank you, Chair. Okay, Mr. Mills, I
14 suppose in aid of the stenographer you and I will try
15 to speak a bit more slowly, if we can. All right. And 11:25
16 we'll move now to look at how things were post 2012.
17 In your statement then you describe how H507 was the
18 Service Manager for the whole of the hospital, and this
19 is about paragraph 33:
20 11:25
21 "Some things came in that changed a role. A
22 resettlement officer was introduced that year, and then
23 H290, who was a Band 8A, was appointed to that role.
24 In around 2013/2014 H189 was appointed to this role and
25 given an additional remit for managing resettlement 11:26
26 wards."
27
28 Then you describe how you were dealing with major
29 issues, delayed discharge, overcrowding, people stuck

1 in the hospital for ages, and failings identified by
2 the RQIA. You had temporary staff, but there was
3 strong morale and a focus on good patient care.
4
5 "When H299 was appointed to the role in around 2016 or 11:26
6 2017, she did not have the responsibility for managing
7 resettlement wards."
8
9 Your best experience was when you were based in day
10 care services buildings, and this is something you 11:26
11 talked about before the break. And then of course, as
12 you talked about before the break, you moved into the
13 administration building and you talk about how things
14 change.
15 11:26
16 "After 2012 there was a new management structure and a
17 massive push for resettlements and H105 worked very
18 hard on this."
19
20 You talk about the issues you just mentioned and poor 11:26
21 RQIA reports, but you worked through them. Your role
22 changed significantly as other events went on in the
23 hospital, and here then you mention an investigation
24 into the Erne Ward and a review done by Aine Morrison,
25 and the Inquiry has heard evidence about that directly 11:27
26 from Ms. Morrison and others involved.
27 DR. MAXWELL: Can I just clarify, because Ms. Morrison
28 calls it Ennis Ward and you call it Erne Ward.
29 A. It says -- Ennis, yeah, Ennis.

1 90 Q. MR. McEVOY: You didn't see the report but there were a
2 number of recommendations and you were asked to give up
3 day care services, which H283 took over, and you
4 focused more on the development wards. You were being
5 called Senior Manager/Operations Manager. 11:27
6
7 Did you ask to see the report, what the Inquiry knows
8 as the Ennis Report?
9 A. I never actually knew there was a report until many
10 years after. I didn't realise there was a report done 11:27
11 on it. I had asked informally when the report -- but
12 it was never shared with me. And in fact I don't --
13 91 Q. So there's two things there. You didn't realise there
14 was a report until many years afterwards?
15 A. Yeah. 11:28
16 92 Q. Until how many years afterwards?
17 A. Oh, I'm sure it must have been 18 months or two years.
18 93 Q. Right. So it's at least some time in 2013 or 14 before
19 you were aware of a report?
20 A. Mhm-mhm. Yeah. 11:28
21 94 Q. Were you given any -- I mean you talk about
22 recommendations there in that paragraph. Did you know
23 where the recommendations came from, because they had
24 an impact on your role?
25 A. Well, no. Well, I think the one where they changed the 11:28
26 senior manager over to just managing day services, that
27 was H823, that was -- I think that was a request, I was
28 told by H507, that it had come from John Veitch.
29 95 Q. Right.

1 A. Because she had only worked part-time. She I think
2 worked maybe two days a week to take over just the day
3 care services, and they were wanting to do a review of
4 day care services anyway.
5 96 Q. So you were -- 11:29
6 A. That was the only recommendation I knew.
7 97 Q. So you were told it was something that was coming from
8 Mr. Veitch as opposed to something that was arising
9 from the Ennis Report?
10 A. I'm assuming -- I assumed at that time it was a 11:29
11 recommendation from that review or it with it. The
12 other bit was the Ward Sister was moved, and that come
13 from H507. I don't believe that come from the
14 recommendation from the review. I think that was
15 during -- the review was still being done at that time. 11:29
16 But that was only the other recommendation that the
17 Ward Manager that was put in there temporary was to
18 stay in that ward and the other one moved.
19 98 Q. Slow down a wee bit so we get this.
20 A. Sorry. 11:29
21 99 Q. You're okay.
22 A. The Ward Sister that was in there temporary, when the
23 Sister was there, was moved to another area of the
24 hospital.
25 100 Q. Okay. 11:29
26 A. And I think there was a Ward Manager moved out of
27 there.
28 101 Q. Well then as a matter of interest, can you tell us how
29 it was that you came to learn about the existence of

1 the Ennis Report?
2 A. I think it must have been around 2016 I think?
3 102 Q. Well a few minutes ago you said it was 20 -- it was
4 about 18 months afterwards you said --
5 A. Oh, I just knew there was a report on it. Oh, when I 11:30
6 -- when there was any real talk about it was 2016, but
7 it was probably about two years after it that I had
8 heard there was a report done. But I was told at an
9 operations meeting there was no significant findings to
10 that effect in it. 11:30
11 103 Q. Okay. So you said -- a few moments ago you said 18
12 months afterwards. There you said two years.
13 A. Well, it's 2014.
14 104 Q. Right.
15 A. I think whenever there was a police investigation at 11:30
16 that time and a prosecution, that's when I would have
17 heard maybe there was a report coming from
18 safeguarding.
19 105 Q. Right.
20 CHAIRPERSON: Sorry. 11:30
21 A. I wouldn't normally have got a Safeguarding Report.
22 MR. McEVOY: Just pause there for a second.
23 CHAIRPERSON: Just stop for a second. You were told
24 that there were no significant findings?
25 A. Mhm-mhm. 11:30
26 CHAIRPERSON: Do you actually recall that being said at
27 a meeting?
28 A. Well, I'm saying no significant findings. When would
29 that would have been?

1 CHAIRPERSON: And you said it was at an operations
2 meeting.
3 A. Yeah, I think it might have been an operations meeting
4 with our -- internally with -- like not ward managers,
5 with H507, there was no recommendations that would have 11:31
6 affected my area.
7 CHAIRPERSON: Oh, I see. Okay.
8 DR. MAXWELL: Can I just go back to the beginning?
9 Were you aware that there had been an incident and
10 there was a safeguarding investigation. 11:31
11 A. Oh, absolutely, yeah.
12 DR. MAXWELL: So you knew there had been something?
13 Because it was quite a new arrangement --
14 A. Yes, because I done -- the first night it was taken
15 over I done -- but I had no involvement with liaising 11:31
16 with relatives or anything to do with safeguarding in
17 it.
18 DR. MAXWELL: So there was an incident that was
19 happening. It wasn't on one of your wards. You knew
20 there was a safeguarding investigation. But what 11:31
21 you've also said is you wouldn't expected to have seen
22 that report --
23 A. And Aine was quite --
24 CHAIRPERSON: Just wait for the question to be
25 finalised. Sorry. 11:32
26 DR. MAXWELL: Okay.
27 A. Sorry. Well, Aine was very clear from the onset of the
28 safeguarding bit of it that I -- because I had a
29 relative that had worked in that, that subsequently

1 went to the community, worked in that unit. So it
2 wouldn't have been right that I would have any sort of
3 -- I wouldn't have done the observations on the ward or
4 anything to that effect, nor would I wanted to. But I
5 think when the first day of it, for instance, I maybe 11:32
6 was on-call, or I was on the ward for that period, and
7 then an RQIA came in the next morning to it, and then
8 it was taken under safeguarding after that. But I
9 wouldn't have been involved in anything in relation to
10 safeguarding. 11:32
11 CHAIRPERSON: So in terms of whether there were
12 significant findings, so far as you were concerned in
13 affecting your ward.
14 A. No.
15 CHAIRPERSON: The comment was made in that regard. 11:32
16 A. Mhm-mhm.
17 CHAIRPERSON: All right. Thank you. Sorry,
18 Mr. McEvoy. Can you just remember, you do -- you speak
19 very quickly, and I know you want to get out of here
20 perhaps -- 11:32
21 A. Oh, absolutely not, no. I just speak quickly.
22 CHAIRPERSON: Just take you time. All right.
23 106 Q. MR. McEVOY: So Mr. Mills, moving just to the next
24 paragraph, 36. Here you tell us:
25 11:33
26 "It was difficult to focus on wards as large numbers of
27 temporary staff and new ways of recruitment, such as
28 expression of interest were being used."
29

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1 You say previously you would have advertised, make
2 application for budget, or internal trawl through the
3 Belfast Trust, but most posts had been externally
4 advertised.
5 11:33
6 "I had the feeling that Muckamore management felt we
7 would have too many staff from the old hospital to the
8 new hospital as resettlement wards closed, so they
9 stopped permanent recruitment. Internal recruitment
10 became by way of expression of interest for promotion 11:33
11 posts. External recruitment was only used for more
12 junior members of staff and was for temporary posts. I
13 recall we externally recruited only for health care
14 assistants and Staff Nurses Band 5."
15 11:34
16 Can I ask you just a couple of questions about the
17 issue of temporary staff. Did temporary staff tend to
18 stay on or were they short lived in terms of their --
19 A. They stayed.
20 107 Q. Yes. 11:34
21 A. Quite a few of them. With the aim that everybody,
22 including myself or Ennis, knew that we were never
23 going to meet our staffing requirements.
24 108 Q. Yes.
25 A. With resettlement, and the sheer number of bank hours 11:34
26 that we were using. So they always had the hope that
27 they would become permanent at some stage.
28 109 Q. Yes. Well, just on that point. Did they convert from
29 temporary to permanent, like formally, were they issued

1 with --
2 A. A small number did after four years. I think it was
3 2015 or 16. They changed it because I think it was if
4 you were four years in a temporary post you either had
5 to let them go or you were made permanent. 11:34
6 110 Q. By operation of law?
7 A. Mhm-mhm.
8 111 Q. Okay.
9 A. They didn't stay in -- they didn't actually stay in the
10 area that they had done the four years. 11:35
11 112 Q. Right.
12 A. They were moved then to places like Erne and Ennis.
13 113 Q. Was that true of all of those temporary --
14 A. At that time, yeah.
15 114 Q. -- now permanent staff? 11:35
16 A. Yeah.
17 115 Q. In terms of quality, were the temporary staff as good
18 as, not as good as permanent staff?
19 A. Absolutely. They were excellent. We had -- they had
20 their induction training, and I mean anyone that had 11:35
21 stayed three years, they got to know their patients,
22 they got to know the routine of the ward, and that's
23 the type of thing that frustrated me in many ways,
24 because they were made permanent, and with that, the
25 induction that they had and the skills that they had 11:35
26 built up, particularly among the health care support
27 workers, that was all transferred.
28 116 Q. Okay.
29 A. That was transferred then to another unit. But the

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1 other thing with them, when they became permanent and
2 they'd be made permanent in Erne, they were told that
3 --
4 117 Q. Let the ambulance go past. Sorry.
5 A. Their contract was not for Muckamore Abbey, it was -- 11:36
6 and they were told very clearly at that time, which
7 upset quite a few of them, that whenever Erne or Ennis
8 Ward that they moved into closed, they would be
9 relocated to somewhere else within the Belfast Trust.
10 118 Q. And was there a reason for that, why they would be 11:36
11 relocated? Were you given a reason?
12 A. Yes, because then we were sticking closely to this
13 budget build up of so many health care support workers,
14 so many staff nurses, and so many -- well trained staff
15 rather than going -- and we had to keep that numbers. 11:36
16 It was very frustrating for them and me.
17 119 Q. And then you go on at 38 to say that:
18
19 "The situation was made worse following a poor RQIA
20 report in 2013 or 2014 into the Iveagh Centre which 11:36
21 reported to Muckamore Hospital management."
22
23 A. Mhm-mhm.
24 120 Q.
25 "They, like the rest of the hospital had only been 11:37
26 recruiting for temporary roles, and as a result of the
27 report and as a result of a lack of interest in
28 temporary roles in the Iveagh Centre, the hospital
29 recruited for a number of permanent roles. So when

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1 they advertised permanent jobs I lost a number of staff
2 members, some of whom had been in post for a number of
3 years."
4
5 Can you tell us a bit more about that, because on one 11:37
6 reading it sounds like staff leapt at the chance to go
7 for a permanent post? Were there any other advantages
8 to them going elsewhere?
9 A. Well they were there -- it was to fill just permanent
10 posts. Yes, there was a recommendation I think from 11:37
11 RQIA that they filled these temporary posts, but
12 equally so I was sitting with as many temporary staff,
13 we had trained them up, we had them well supporting
14 patients in the core hospital, and helping with both
15 behavioural plans and discharge plans, and their hearts 11:38
16 was in working in Muckamore Abbey.
17 121 Q. Yes.
18 A. And I had a number of them had -- officially when they
19 graduated from Queen's, specifically asked for certain
20 wards to work in, and they stayed in them temporary 11:38
21 posts. So this permanent post become available in
22 Iveagh, and they went, and I'm sure that they were very
23 good, but we also got them back again. As soon as we
24 advertised for permanent posts they came back. So
25 their heart was in the hospital. But then I had to 11:38
26 re-recruit again at a temporary level. I still wasn't
27 getting permanent staff. So I was being disadvantaged
28 with it. And it wasn't that I had any issue with
29 Iveagh and it, but the staff in the hospital couldn't

1 understand, well, why would they get it? Why are you
2 giving permanent posts there and not giving them here?
3 CHAIRPERSON: Can you just help me, it maybe obvious,
4 but the advantage of having a permanent post is that
5 you have job security. 11:39
6 A. Mhm-mhm.
7 CHAIRPERSON: Does it affect pension or anything like
8 that?
9 A. No, I think they could still pay into your
10 superannuation when you're temporary as well. 11:39
11 CHAIRPERSON: And it wouldn't affect the actual wages,
12 because the wages presumably the same?
13 A. No, supernumerary each year.
14 CHAIRPERSON: So it's really just job security.
15 A. That's it. 11:39
16 CHAIRPERSON: Yes.
17 122 Q. MR. McEVOY: And in terms of the report that you had
18 mentioned into the Iveagh Centre, were any -- was there
19 anything by way of transferred learning or lessons
20 learned that was applied into the main hospital at 11:39
21 Muckamore itself?
22 A. Yeah, but we just didn't get the resources to come with
23 it. They got a massive increase in their Psychology
24 Department in it.
25 123 Q. Iveagh did? 11:39
26 A. Oh, yeah.
27 124 Q. Yeah.
28 A. An increase in their staffing levels, additional
29 training, time out for training, and a focus on a whole

1 variety of different types of training. But it was
2 seen -- it was an excellent opportunity. I actually
3 turned down the opportunity. I could have moved to
4 Iveagh at that time, I was offered the Senior Nurse
5 Manager's post in it, but I stayed within the hospital, 11:40
6 but there was -- and my staff could see that, they
7 could see they had time out for training, a week nearly
8 of training, and we were sending relieve staff into
9 Iveagh to allow that training to go on.
10 125 Q. So the RQIA recommendations were confined to Iveagh? 11:40
11 A. Mhm-mhm.
12 126 Q. Whatever they recommended was confined to Iveagh in
13 terms of staffing, and resource, psychology and so on?
14 A. Yep.
15 127 Q. But the question is really more about were any of those 11:40
16 recommendations and lessons fed back into the hospital,
17 the broader hospital community --
18 A. Yes, the senior nurse manager --
19 128 Q. -- given that it was under -- Iveagh, that is, was
20 under Muckamore management? 11:41
21 A. Yeah, one of the ones was that we would apply for Royal
22 College of Psychiatry accreditation.
23 129 Q. Right.
24 A. Because Iveagh had got that for children's services.
25 130 Q. Yes. 11:41
26 A. And I thought this was a good chance here. It was a
27 good opportunity, and I'll do this, because I maybe
28 could get additional staff, we could get additional
29 psychology, we could get the additional medical staff

1 into it.
2 131 Q. Yes.
3 A. And to my astonishment we got accredited for the award
4 without the additional staff, but we sort of -- and
5 used it as a benchmark. But that would have been what 11:41
6 we would have used. We also acknowledged that there
7 was a need for the behavioural team to be based within
8 the Psychology Department, and I had no qualms, I
9 thought that was the right place for them to be, and I
10 think it improved by doing that, because we had 11:41
11 psychologist assistants, behavioural nurses, all
12 working together, and I thought it was much better both
13 for resettlement and the core hospital itself.
14 DR. MAXWELL: Was there anything in the Iveagh Report
15 that wasn't about resources that was about practices 11:42
16 that were either poor or had been superceded by new
17 evidence based practices that could apply to Muckamore.
18 A. Yes, the seclusion. They used a number of what they
19 call therapeutic techniques in it to reduce seclusion.
20 But what I could see -- I couldn't necessary -- when 11:42
21 there was a reduction in seclusion you could see that
22 there was still physical intervention being used at a
23 higher level. But I think it was more around the team
24 building time out for training was the most important
25 bit that I -- and we still weren't getting that time 11:42
26 for training. We were cramming training together.
27 They had specific weeks out for training, where we
28 didn't.
29 DR. MAXWELL: So are you saying the Iveagh Report

1 raised concerns about the use of seclusion?
2 A. I think so, yeah, if I can remember.
3 DR. MAXWELL: Did that trigger anybody to say 'oh,
4 perhaps we should could an internal review of the use
5 of seclusion in Muckamore'? 11:43
6 A. Not to my knowledge. It may have happened, it may have
7 been discussion at the hospital management team, the
8 core management team.
9 DR. MAXWELL: But you weren't there?
10 A. No. 11:43
11 CHAIRPERSON: And so that they at the Iveagh could
12 undertake training, they were denuding your staff?
13 A. Yeah.
14 CHAIRPERSON: To ensure that happened, which would mean
15 it less likely that your staff were going to be able to 11:43
16 get training?
17 A. Yeah. We often sent staff on relief to it, and some of
18 the behavioural team that was in the adult services
19 would have went to support them as well. But I felt it
20 was right to support them too. But it never changed. 11:43
21 Even right up until 2016/17, if there was an incident
22 in Iveagh and they needed staff support, we still had
23 to transfer staff up there at short notice.
24 CHAIRPERSON: Yes.
25 132 Q. MR. McEVOY: So you have described, and you've 11:44
26 described in the body of your statement, and we have
27 talked and you've discussed in your evidence the
28 workforce issues that you were confronted with and a
29 shift to temporary staff and reliance on it. At

1 paragraph 40 you say:
2
3 "I was dealing with a workforce where a number of staff
4 members had been in their posts for up to four years on
5 a temporary basis and they had experience of the 11:44
6 hospital you would need for permanent staff."
7
8 You had already touched on how some of them became
9 permanent. But then you talk about the re-allocation,
10 and we've touched on that: 11:44
11
12 "It was a bad arrangement..."
13
14 -- and this was something as well we've already touched
15 on in your evidence, you were sitting with a colossal 11:44
16 amount of bank hours, but once staff were made
17 permanent they were moved away from the hospital. You
18 think that might have changed subsequently after your
19 retirement.
20 11:45
21 During that time when you were facing those chronic
22 issues, did you feed them back up the chain to your
23 management?
24 A. Oh, absolutely. Every day.
25 133 Q. Yeah. 11:45
26 A. I actually completed -- at one point I devised a
27 template for to be recorded in the nursing office,
28 there was a Duty Officer each day, and they would have
29 come to me, even though there were other senior

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1 managers in the hospital, but for the first port of
2 come was to reduce our day services to send staff on
3 relief to wards or to Iveagh. So what we were actually
4 doing, there was no -- we tried for banking hours,
5 we've tried for overtime, and in some cases agency, so 11:45
6 I was closing areas of day care to relocate staff to
7 the wards, and it was mostly to cover their constant
8 supervisions or high levels of obs, but then
9 subsequently the patient didn't get off the ward and
10 they lost out on their day-time opportunities as well. 11:46
11 So that was frustrating for the staff who had a day
12 care programme done on to it, developed for that day,
13 and it was frustrating for the patient. But it was --
14 paramount was to keep the ward safe at that stage.
15 11:46
16 Other things that I would have done, and it come back
17 on me and the staff as well, because when times of
18 really difficult staffing, particularly during the
19 Ennis period when the staff were having to be
20 supervised working in them areas, and in later years 11:46
21 too, but I would have had to went out into the day care
22 staff, and many of them worked as bank nurses, and
23 asked them would they maybe finish -- close day care
24 earlier on a Friday, if there was going to be
25 difficulties on the Friday evening or Saturday 11:47
26 covering, particularly in the evening, and let them go
27 off early to come back in at night to bank as maybe a
28 healthcare support worker, to subsidise the wards, and
29 I did that, sometimes on a regular basis, until the

1 staffing -- now they recruited it at a temporary level
2 to bring staff in, and it wasn't just on my wards, it
3 was right throughout the hospital.
4
5 But, again, the staff -- and they were really willing 11:47
6 to do this, they were more than helpful, and then they
7 got into a routine on their bank of maybe working a
8 Friday night or a Saturday night. So staffing levels
9 for some periods improved. But the staff got
10 frustrated, because another senior manager in some of 11:47
11 the areas would have pulled them up or questioned them
12 'you're not keeping to your working time directive',
13 and it started off as a favour for us, we were thanking
14 them for doing it, we couldn't have existed without it,
15 and then it just got into a routine, and then they were 11:47
16 being almost challenged for not sticking to a working
17 time directive. So they got quite frustrated. Instead
18 of being thanked or rewarded in some way for doing the
19 hours, they were being questioned about it. So that
20 was difficult for the staff to accept. 11:48
21 134 Q. At paragraph 41 we have covered a lot of the territory
22 earlier in your evidence this morning in terms of what
23 you discuss here, and this is around your interactions
24 with the Society of Parents and Friends of the
25 Hospital, and the questions posed by resettlement and 11:48
26 staffing issues. We also touched on combining of wards
27 and the effect of that on patients and, of course, on
28 staff. Do you know -- a certain issue can be where the
29 decision about combining wards came from?

1 A. It would have been hospital management team would have
2 authorised that.
3 135 Q. So it would have been within the hospital? Not at a
4 higher level, but it would have been hospital
5 management? 11:49
6 A. I would have assumed that they should have went to
7 higher level. I don't think that a co-director should
8 have made that decision. But it could well have come
9 from that direction. But that's where I would have got
10 notification from it. 11:49
11 136 Q. Did combining wards then mean that staff numbers
12 reduced or did they stay the same?
13 A. No, they improved for a short period of time.
14 137 Q. Okay. For how long?
15 A. You would have probably seen an improvement for three 11:49
16 to six months. But staff would have told me then there
17 would have been difficulties in them wards with the
18 patient groups, so that staff maybe had to be enhanced
19 on that ward. But I didn't see any improvement. There
20 was no improvement in the core hospital wards because 11:49
21 people were still in temporary posts, and things like
22 what we talked about Iveagh situation, I lost staff
23 then.
24 138 Q. Yes.
25 A. So it would have went down. There'd have been another 11:50
26 crisis come along, because it didn't -- nothing
27 happened in relation to recruitment unless an incident
28 happened, whether it be an RQIA report or something to
29 that effect, and then we seen temporary improvements.

1 DR. MAXWELL: Can I ask you about the stability across
2 that time, because we've heard a lot of evidence about
3 a staffing crisis from March 2012 up until the Ennis
4 Ward safeguarding incident, and then we've heard less
5 about what happened then, but then in 2017 we've heard 11:50
6 there were shortages. Was there, was there a crisis in
7 2012 that was worse than previous crises? Did it get
8 better and there was still problems but it wasn't as
9 bad as 2012? What did it look like?
10 A. No, it wasn't any worse than 2012. 2014, I would argue 11:50
11 when we started to see our staffing crisis.
12 DR. MAXWELL: Right.
13 A. Serious crisis. We managed it through banking,
14 overtime and, yes, it was difficult, on some of the
15 wards it was difficult, but -- and we had worked 11:51
16 through it. I would 2009, '10, '11, there were
17 difficulties, and it may have seemed to the new
18 management system coming in that this was a major
19 crisis, but at the same time they were doing a project
20 where they were going to reduce our number of health 11:51
21 care support workers and increase the number of trained
22 staff, and that I think brought a staffing crisis to
23 them on paper, because they were saying, look, you
24 couldn't work with 40 to 60% unqualified to 40%
25 qualified. And that may seem difficult, but we were 11:51
26 running with, at that time, maybe 50 to 60% of delayed
27 discharges. So 40% didn't mean that every ward sat
28 with 40% trained staff. You sent your trained staff to
29 the areas that were of most need, and that's how I had

1 learned to work from maybe 2008, '09, '10, you sent
2 them -- if you needed a high level of trained staff in
3 this particular area, you maybe need less in this area.
4 But that was overall. There may well have been -- we
5 used a thing called Telford coming into -- that's fine 11:52
6 in an acute general hospital in it, but it didn't
7 always take account -- and the worst scenarios as
8 possible we put the Telford in, or my ward managers
9 did, but it didn't always work that way. One of the
10 best resources we had in that hospital was health care 11:52
11 assistants. There was a lot of people -- a learning
12 disability hospital, and I may be going off on a
13 tangent again, but a learning disability hospital, and
14 I'm not going to say anything different, it's an
15 institution and I grew up working in an institution, 11:52
16 but to keep it right it needs a full team of people,
17 and health care assistants, your hotel services staff,
18 your estate staff are vital to make it running, and
19 that's your eyes and ears. It's not run just by
20 doctors and nurses. The best units that I had when we 11:53
21 had everybody working altogether, you had the best
22 units. But we were moving more to a doctors and nurses
23 hospital. And we were always criticised over the years
24 about having a medical model, but actually in our
25 modern days we were moving more to just doctors and 11:53
26 nurses, and I think that we have a place for every
27 single discipline that you could want working together
28 with them.
29 DR. MAXWELL: But did I hear you say you thought that

1 the time of most crisis with staffing, whichever staff
2 group we're talking about, was 2014.
3 A. '14. Yeah.
4 DR. MAXWELL: And why -- what triggered that crisis in
5 2014? 11:53
6 A. Trying to enhance your trained staff levels. The
7 restrictions on banking hours, they were very -- what
8 hours that people could bank on it as well. We were
9 starting towards looking at agency. We had never
10 really looked at agency in Muckamore. It wasn't to 11:54
11 keep out people, it was far from that. Expression of
12 interest, because you weren't bringing new blood in.
13 And I have never, in all my time in the hospital I had
14 never seen posts being appointed on expression of
15 interest, and that itself -- because you had no proper 11:54
16 backfill.
17 DR. MAXWELL: Okay.
18 CHAIRPERSON: So the intention may have been good to
19 try to enhance a trained staff, but there were lots of
20 unintended consequences. 11:54
21 A. Yes. And Queen's wasn't training enough. We were
22 never going to get -- someone needed to speak to
23 Queen's or the Department of Health, we needed more
24 people to be trained. We were never going to get to
25 that level. And yet we were redeploying healthcare 11:54
26 assistants that would have been vital to our service,
27 because we were short. We were making our own crisis.
28 CHAIRPERSON: Yes.
29 139 Q. MR. McEVOY: At the very foot of the page, the start of

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1 page 42, you say that:
2
3 "There were duty managers who brought any incidents to
4 me..."
5 11:55
6 - this is after the combining started to take place:
7
8 "We had to spend people out on relief as we had so many
9 temporary staff."
10 11:55
11 Looking back, Mr. Mills, do you know -- can you reflect
12 on whether sending staff on relief to wards they didn't
13 know or weren't familiar with contribute to patient
14 distress?
15 A. Absolutely it did. I have no doubts. Particularly the 11:55
16 closing of day care services distressed patients
17 immensely by doing that. Looking back on that, I
18 didn't realise -- plus it put the staff -- I had every
19 confidence in my day care staff because they knew
20 patients from right throughout the hospital. So I was 11:55
21 comfortable with them going into the areas, that they
22 weren't going in blind, they knew the patients and
23 that. They were probably the best group of staff that
24 you could send on relief, but the fact on it was that
25 somebody is being confined to a ward or very little 11:56
26 stimulation. And I seen that -- I witnessed -- had an
27 opportunity to see some of the CCTV before I left and
28 you could see the effect on that.
29 PROFESSOR MURPHY: So do you think that if we looked at

1 rates of incidents around 2014, we'd see a big
2 increase, partly because of day care being closed?
3 A. I would say you could, yeah. You might. You could
4 look at the days of it, and if that data -- there
5 should -- well I'm not saying it should be there 11:56
6 because we didn't record it just for the sake of
7 recording it, but I thought at that stage it was fairly
8 untoward when we would have closed the day care service
9 up until then, but the day care staff and the staff
10 side organisations, they just weren't happy with it, 11:57
11 and they were acting on behalf of the patients too, so
12 I felt it useful to make a note of that decision that
13 was made by the Duty Officer and me, and why we done
14 it, and the effects on patients.
15 PROFESSOR MURPHY: Thank you. 11:57
16 140 Q. MR. McEVOY: And you go on then and say that staff --
17 the point you've already made about the staff having
18 been sent to the Iveagh Centre via taxi and, again,
19 staff not being placed on wards with which they were
20 familiar, or being placed on wards with which they were 11:57
21 unfamiliar.
22
23 At 43 you then say you had to reduce senior day care
24 workers from four to one, as one retired and one moved
25 to behavioural services. No recruitment and therefore 11:57
26 already no entertainment activities. The staff
27 themselves were very frustrated by this. How were you
28 made aware of that, that sense of staff frustration?
29 A. I was speaking to the people.

1 141 Q. Yes.
2 A. This was budget led do this. We were doing -- I was
3 expected to do this and we hadn't the patients
4 discharged. This was all part of a resettlement
5 programme that would have allowed patients to have 11:58
6 moved on. But what they weren't taking into account
7 was the complexities of the patients that were being
8 admitted. I mean, that senior day care worker had no
9 training in behaviour, she had a psychologist degree
10 that she maybe would done 20 years ago, but it wasn't 11:58
11 -- just because there was funding for that post, they
12 went into it, and another one retired. But it was
13 budget led, them decisions.
14 142 Q. Okay. In the following paragraphs then, once again you
15 sort of cast your mind back and give the Inquiry an 11:58
16 overview of your recollection, as you have done earlier
17 in your evidence today, about sort of the holistic
18 view, if you like, of your experience over the years
19 working in Muckamore, and I'll summarise it, if I can,
20 in the following way, and this is in the context of 11:59
21 your appointment in January '17 as the Senior Manager
22 on Erne. You observed that over the years, over the
23 decades, there was a culture change on the wards in the
24 hospital. In the early 1980s and early 1990s, and this
25 was a theme earlier in your evidence this morning, the 11:59
26 culture was to make the hospital as homely as possible
27 and to provide entertainment services, therapeutic and
28 community services.
29

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1 "There was a focus of continuous improvement
2 development of services."
3
4 You say that:
5 11:59
6 "There were a large number of visits from various
7 colleges and the buildings were getting better. At the
8 height of the Troubles..."
9
10 - you believe:
11
12 "...the hospital's development was negatively effected
13 by this due to resettlement and funding then became
14 more limited."
15 11:59
16 You talk about how there was always a senior management
17 presence during the 1990s. You recollect that the site
18 director had an office on-site. You talk about how
19 Mr. Black, Richard Black, who was the Chief Executive
20 and Non-Executive Director, was influential over the 12:00
21 design and structure of the buildings.
22
23 "They would have been regularly on-site due to the poor
24 state of buildings and lack of funding. When untoward
25 incidents took place it wouldn't have been unusual to 12:00
26 see Directors such as Eamonn Molloy..."
27
28 - who was the Human Resources Director, or Oscar
29 Donnelly, who was the business manager:

1
2 "...providing managers at the hospital with advice and
3 support."
4
5 You talk about how, in the next paragraph, 48, there 12:00
6 was a feeling from the most junior to the most senior
7 levels of staff. They wanted to make the hospital
8 better and to develop community services. They were
9 forward thinking.
10 12:00
11 And you go on to give more examples then about how you
12 were pushing for new units and how each inspection
13 would highlight poor condition of buildings.
14 Inspections, for example, carried out by, among others,
15 the RQIA, and the Mental Health Commission, which were 12:01
16 critical of the hospital. You remember nurses bringing
17 in their own paints and artists to make the walls more
18 colourful. And then you say that in the 2000s there
19 was a focus on resettlement, which we have obviously
20 discussed in some detail, but you say: 12:01
21
22 "No-one really knew how many beds we would need in the
23 core hospital of the future. They started by designing
24 it as a 120 patient hospital and then reduced it down
25 to 60. The first workforce plan focused on an estimate 12:01
26 of 100 patients. We knew there was a reduction of
27 learning disability nurse training, so at this point
28 they had it as 40% qualified staff and 60% unqualified,
29 because the majority of patients in the new core

1 hospital would not be requiring active treatment."
2
3 On that score, given that uncertainty about numbers for
4 the new hospital, do you know -- there is uncertainty,
5 but do you know where calculations about numbers came 12:02
6 from, even to arrive at what the population of the
7 hospital -- the patient population of the hospital
8 might have been?
9 A. Well I think it was agreed by the Department of Health
10 and the senior managers within the Belfast Trust at 12:02
11 that time, and there was some discussions with senior
12 managers in the hospital, not at my level, how many
13 beds would be required. That time they were looking at
14 providing a service for the whole of the Northern
15 Ireland, because we were with only an hour's drive. 12:02
16 143 Q. Yes.
17 A. So I think it was based on negotiations with the other
18 Trusts, not just Muckamore Abbey, how many beds you
19 would require. Because I was constantly hearing that
20 the Western Trusts had commissioned so many beds, the 12:03
21 Southern Trust had commissioned, so I think that is
22 where it come from, and I think then people started to
23 panic, and then various Trusts' -- money had been taken
24 from their community development.
25 144 Q. Yes. Sorry, sorry for interrupting you. So the 12:03
26 intention was that this was going to be a regional
27 facility?
28 A. Oh, absolutely, yeah.
29 145 Q. And then, if I understand you correctly then there was

1 -- there was no -- was there no sort of joined up
2 thinking between each of the Trusts in terms of how
3 many were actually going to feed into the number that
4 was going to be arrived at?
5 A. Yeah, there was, yeah, at that time, because there was 12:03
6 so many -- it was broken down into each Trust of how
7 many beds was to be in Six Mile, that was to be --
8 146 Q. Right.
9 A. Particularly the forensic ones. But I think they
10 changed as time went on. 12:03
11 147 Q. Yes.
12 A. They decided, 'Right, well we'll develop Bluestone and
13 we'll develop a unit in Derry for that matter', and
14 they'll have so many beds in their acute admission down
15 in Stradreagh. So that brought our numbers down a bit 12:03
16 as well.
17 148 Q. More fundamentally, what you say in this paragraph is
18 that the objective for the hospital is that the
19 patients would not need active treatment?
20 A. Out of that -- 12:04
21 149 Q. Yes.
22 A. Well, the objective was that if we needed 100 patients
23 that each one of them would need active treatment
24 within a short period. They'd be followed in with
25 their community teams, and after a short period of 12:04
26 assessment and treatment they would be discharged with
27 treatment within a community setting. But what people,
28 I don't think have got on to, is that, yes, we were
29 getting new money for new buildings, no matter how many

1 we were getting, but the community resources were not
2 being put in. The money wasn't being put in for the
3 community teams to develop their services within,
4 should it be behavioural services, or whatever, that
5 wasn't being done. And I can remember very clearly at 12:04
6 the first public announcement of the redevelopment of
7 Muckamore Abbey Hospital, and it was in early 2000s --
8 there was local MLAs, or whatever they were,
9 politicians there, there was people from the
10 Department, it was packed at a meeting, showing up the 12:05
11 pictures of the new buildings, and it looked wonderful.
12 The staff were so excited, and so was I. We were
13 absolutely delighted. But a man got up and spoke at
14 this, and I have great admiration for him, and I
15 thought he was a great leader within Learning 12:05
16 Disability Services, Roy McConaghy, and me and him, we
17 didn't have words, but I didn't agree with what he said
18 at the time, but when I look back he was 100% right.
19 He stood up and said isn't it sad today that we're
20 planning to build a hospital for 100 people with 12:05
21 learning disability in a small country like Northern
22 Ireland, and we're expecting to see 100 people in it.
23 And he was 100% right. We should have been developing
24 the services within our communities and building a
25 small 40-bedded unit for very complex, difficult cases 12:06
26 that required a learning disability hospital, not
27 necessarily a mental health, but required a learning
28 disability hospital regionally, and 40. And they kept
29 to them numbers. But he was 100% right in it, and I

1 think that would have been -- but I thought, well, you
2 know, you should be happy that we're having this since
3 -- but it wasn't -- he was right.
4 PROFESSOR MURPHY: So can I clarify, was that before
5 the Bamford Review? 12:06
6 A. Oh, yeah, way -- yeah. Absolutely it was, yeah. But
7 he was right what he was saying. But it wasn't -- I
8 don't know what way it was taken. But I didn't take it
9 up that way at that time, he just felt that it was
10 wrong to be building it, but the services -- he had an 12:06
11 insight, you know, that the resources weren't being put
12 into our community services.
13 CHAIRPERSON: But he really thought it should be
14 smaller.
15 A. Absolutely. 12:06
16 CHAIRPERSON: In order to deal with acute cases, as it
17 were --
18 A. I think Roy's feeling would be that we should have the
19 services there to support them in the home right
20 throughout. 12:07
21 CHAIRPERSON: Yes.
22 A. To prevent any admission. But realistically he would
23 have a much smaller number.
24 150 Q. MR. McEVOY: So just in fairness to you, Mr. Mills,
25 just in terms of the last paragraph of paragraph 49, 12:07
26 you say:
27
28 "This was because the majority of the patients in the
29 new core hospital would not be requiring active

1 treatment."
2
3 Is what you mean there then, once discharged into the
4 community, is that your point?
5 A. Yes. 12:07
6 151 Q. Thank you. So then at paragraph 50 you talk about how
7 in the period from 2004 to 2010, and we're going back a
8 little bit, but it is important:
9
10 "Staff wanted to get into working on the core hospital 12:07
11 wards and to be involved in assessment and treatment.
12 The plan was that we would not need large day care
13 service or the entertainment services to the extent
14 that we had because patients were to be admitted for
15 short periods for assessment and then discharged and 12:07
16 treatment continued in the community. It didn't happen
17 in practice."
18
19 Now we've touched on uncertainty over numbers, and the
20 lack of an obvious basis for the calculation of numbers 12:08
21 for the new hospital, but even when it became clear, as
22 it appears to have over that period of time, that the
23 vision for the new hospital was going to take longer to
24 achieve, do you know whether there was any attempt to
25 revisit the assumptions about beds and numbers and, 12:08
26 indeed, the implications for day care services, et
27 cetera?
28 A. Not really. Yeah, they talked about then less patients
29 in the hospital, but that was their aim to have less.

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1 152 Q. Yes.
2 A. But it wasn't taken into account the sheer numbers of
3 the patients that were currently in the hospital.
4 153 Q. Yes. But I suppose so that you're with me on the
5 question; once it became clear that the idea around the 12:08
6 new core hospital, and what it might look like, and how
7 long it would take to get there, once it became clear
8 that this wasn't going to be something that was going
9 to happen quickly, was there any -- do you remember
10 there being discussion about, right, we're going to 12:09
11 need to keep day care services, entertainment services,
12 or whatever, in place?
13 A. No, never. It was all budget led. And they never had
14 a clear vision of the number. It was always such and
15 such a unit is going to be built in a year's time. 12:09
16 154 Q. Yes.
17 A. Voluntary sector will take -- they'll be taking 20 more
18 and there was so many would be going to here. But you
19 couldn't say that, because neither patient or relative
20 had seen the units. They were only on paper that this 12:09
21 was going to be built in a year's time.
22 155 Q. Yes. Okay. At paragraph 51 then:
23
24 "The vast majority of the time there were great teams
25 and people wanted to work together. There were ups and 12:09
26 downs, such as staff shortages..."
27
28 - which we've talked about.
29

1 "From 2014 onwards, the atmosphere in the hospital
2 changed due to decisions being made and workforce
3 planning delayed discharges for patients and a change
4 in patient profile."
5 12:10
6 You describe how you were getting young people of
7 around 18/19 years old as admissions.
8
9 "These patients had previously been supported in school
10 but were then admitted to the hospital for the wrong 12:10
11 reasons and as patients ended up being stuck there.
12 Community resources did not support them as it could
13 have been a year before the community package was
14 ready. We had complex admissions which has only
15 worsened when patients should not have been admitted at 12:10
16 all. For example, patients admitted from the Iveagh
17 Centre. H50 and I opposed this as patients were
18 delayed discharge but were admitted to Muckamore as no
19 resettlement was available. So they built..."
20 12:10
21 -- and you've put it in quotation marks:
22
23 "..."apartments" for these patients, but they were
24 nothing other than dormitories divided. These
25 "apartments" were scattered throughout the hospital and 12:10
26 they were staffed with one or two nursing assistants.
27 They were inappropriately placed. I cannot imagine the
28 trauma this would have caused the patients. There were
29 at least four patients who fell into this category."

1
2 - and you name P248, P77, P196, and P249 as being among
3 those patients.
4
5 "They were told they were coming for a short period of 12:11
6 time. They eventually moved to segregated parts of the
7 wards as the apartments on the old wards were not safe
8 for patients or staff with the staircases in them.
9 They were still there when I left, despite there being
10 no clinical need for them at Muckamore Hospital." 12:11
11
12 What do you mean when you say that these apartments, or
13 however you wanted to describe them, were
14 inappropriately placed?
15 A. They were in wards that were closing. You really need 12:11
16 to see them. A dormitory. If you've visited Muckamore
17 you maybe have seen one of the old wards that have
18 closed, but you need to see it, and the dormitory was
19 just divided by furniture. I mean these were not New
20 York apartments, refurbished old buildings. They were 12:12
21 just divided. They hadn't got kitchen areas, the
22 kitchen areas were downstairs. They were segregated
23 away from other patients. Yes, there was problems with
24 them mixing with other patients. But the thing that
25 really, you know, the design, the staffing of them, but 12:12
26 these young men and women, they were children one day
27 and they were adults the next day, and they had a
28 discharge plan. They were delayed discharges from a
29 children's unit.

1 156 Q. Yes.
2 A. Surely -- and Dr. H50, he was of the same opinion as
3 mine, they were going to get stuck in Muckamore.
4 CHAIRPERSON: Sorry, he was the same opinion of you?
5 A. Yeah. 12:12
6 CHAIRPERSON: Right.
7 A. And he -- but he was the voice on the hospital
8 management team -- and they did, it upset him and he
9 argued against it. But no child, you know, they just
10 don't become an adult overnight just because they're 12:13
11 18. But the pressure was on me to -- they would be
12 coming to PICU at some stage, or come into the hospital
13 -- they went to the resettlement side of the hospital,
14 but it just was not right.
15 PROFESSOR MURPHY: So they were basically using closed 12:13
16 wards to house these young men who had become 18 and
17 who they couldn't find anywhere for in the community?
18 A. Moylena was one of the wards, and there were only a few
19 patients left in it, and once they've realised that --
20 one patient had come from the core hospital when we 12:13
21 changed Killead over to -- the men from it over to
22 Cranfield 2. One young man came over, he was on a
23 two-to-one, and he didn't mix well with all the other
24 patients. He was to stay there for a short period
25 while, until a discharge went out off the acute side of 12:14
26 the hospital, which probably could have been up to six
27 weeks maybe, two months at the most, and he was fairly
28 well managed within that unit, and he was comfortable
29 with it. But it was a dormitory. It was only a

1 temporary setting. But then once that happened then
2 they decided to bring a child out of Iveagh up into it
3 to the other half of it, and you had stairs going up to
4 it, the use of physical intervention could have been
5 used, and the destruction in the buildings, staff 12:14
6 responses. Now, there was a small number of patients
7 downstairs and they finally moved over to another ward.
8
9 There was another one in Moyola, no, Mallow Ward, which
10 was upstairs, and he was on his own. You can jazz it 12:14
11 up with wardrobes and stuff, but it's just a dormitory.
12 CHAIRPERSON: But there does come a point in one of
13 these patients's lives when they've been at Iveagh and
14 they will have to transfer to an adult hospital, if, if
15 they are transferring them within the hospital system. 12:15
16 A. Yes.
17 CHAIRPERSON: What you're really saying is because a
18 lot of them were delayed discharges when they were at
19 Iveagh, they shouldn't have been transferring into
20 Muckamore at all? 12:15
21 A. Oh, yeah.
22 CHAIRPERSON: But those who did transfer into
23 Muckamore, you're saying they then came into facilities
24 that were inappropriate for them?
25 A. I don't know if any of them come that weren't delayed 12:15
26 discharges. I don't think any of them come from Iveagh
27 for active treatment, or follow treatment through.
28 Maybe after I left. But I can't think of any come
29 without -- they had no discharge plan, they had nothing

1 in place for them. But none come for treatment.
2 CHAIRPERSON: Yeah. Okay.
3 A. Sorry, one did. It was a young man. But he had -- he
4 couldn't be treated within Muckamore. He ended up to a
5 specialist unit in England. 12:16
6 CHAIRPERSON: Yes.
7 A. But he went actually to a ward into the PICU. He
8 wasn't segregated.
9 157 Q. MR. McEVOY: Was there a reason for an increase in the
10 admission of 18 and 19-year-olds around that time? 12:16
11 A. Yeah, my personal opinion would have been that, again,
12 not on, just on Iveagh, but people were transferring
13 from school services, specialist schools, where they
14 had support. The families had good support. I don't
15 think adult services in the community could have 12:16
16 offered the same support at that time. So that's why.
17 158 Q. But on reading your statement it sounds like this was a
18 change, in reading that section of your statement it
19 sounds like this was a change or an uptick?
20 A. Yeah. Yeah. There seemed to be a lot more young 12:16
21 people coming in.
22 159 Q. And my question is, was there a reason you can think of
23 for that?
24 A. I couldn't, no.
25 160 Q. Okay. 12:16
26 A. Sorry, other than there wasn't resources available
27 just.
28 161 Q. Yes. Then you go on then in your statement to talk
29 about how the Nursing Director, Ms. Creaney, came to

1 the hospital on a visit, expressed surprise at such a
2 low level of trained staff in relation to untrained
3 staff in the new hospital. You explained that most of
4 the patients were delayed discharges and required
5 support staff, whereas qualified staff were to deal 12:17
6 with patients who required assessment and treatment.
7 Did she take that on board?
8 A. No. It was still very much focused -- there was a
9 change in my line manager then becoming an Associate
10 Director of Nursing, and it was still a focus on very 12:17
11 highly skilled, high level nurses in the hospital, they
12 were still focusing on 60/40, and I think that changed
13 to over 60/40.
14 162 Q. All right.
15 A. I was basing it with the resources that was available 12:17
16 to us.
17 163 Q. Safeguarding in the hospital changed in 2012 as there
18 was a lot of pressure on the social workers, you say,
19 about safeguarding referrals.
20 A. Mhm-mhm. 12:18
21 164 Q.
22 "H507 appointed a Safeguarding Officer based in the
23 hospital."
24
25 You touched on this earlier. 12:18
26
27 "This is **H201**, who reported to H507 as his line
28 manager. He also reported to Ms. Morrison who was in
29 the Trust Community Learning Disability Service. **H201**

1 was a social worker..."
2
3 - and you felt that it was a myth that you were a
4 Safeguarding Investigation Officer. Were did the myth
5 come from? 12:18
6 A. I wouldn't have -- I done the safeguarding training,
7 but there's no way would I do a safeguarding
8 investigation if it was one of my staff. I never did
9 and never would have. I would have assisted with, if
10 it was a police investigation, in correlating 12:18
11 information.
12 165 Q. Yes.
13 A. But, no, I never done a safeguarding investigation.
14 166 Q. But where do you think the myth came from, this idea
15 that you would have done that role? 12:18
16 A. I think the staff -- maybe relatives or other staff
17 thought that. Because I was going onto the ward, if
18 there was a Safeguarding Officer doing an investigation
19 it was easy for me to go and ask for incident forms,
20 for body charts, bathing records, to get that 12:19
21 information for the Safeguarding Investigating Officer,
22 I would have assisted to give them, but I didn't sit in
23 at safeguarding meetings with them.
24 167 Q. Yes. Yes. And, indeed, you go on and note that and
25 also say that the designated Safeguarding Officer and 12:19
26 investigating officer were not appointed by the
27 hospital or by you, but by the Trust to which the
28 patient belonged. But you would have been involved in
29 the suspension coming from the safeguarding action plan

1 and in any disciplinary investigation arising from
2 safeguarding referrals.
3
4 So at 54 then you say that:
5 12:19
6 "Once a safeguarding referral was made it went to **H201**
7 and the vast majority of those involved
8 patient-on-patient assaults. A phenomenal number of
9 these arose and they referred some to the police. I
10 was concerned as in the hospital you build working 12:19
11 relationships with staff."
12
13 You expressed the belief that:
14
15 "...the Safeguarding Officer should be independent from 12:20
16 the hospital. He had an extensive role which he did
17 carry out to the best of his ability."
18
19 And you:
20 12:20
21 "...provided the Safeguarding Officer with options as
22 to how to deal with a staff member."
23
24 By way of example then, you describe how the member of
25 staff should be suspend, and the only option to deal 12:20
26 with a patient-on-patient incident was to put the
27 patient on a one-to-one supervision. So the patient
28 could go for years on a one-to-one supervision basis.
29 There were referrals made to the Police Public

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1 Protection Unit in relation to staff incidents?
2 DR. MAXWELL: Can I just ask you about this protection
3 plan of the patient being on one-to-one supervision,
4 and you were saying some patients stay on it for years.
5 Was this a protection plan that the Safeguarding 12:20
6 Officer had instituted?
7 A. Mhm-mhm.
8 DR. MAXWELL: And so how would that get lifted? Would
9 the Safeguarding Officer have to lift it?
10 A. They would have -- usually the safeguarding team would 12:21
11 meet together and they would have a multidisciplinary
12 meeting and they'd decide then if it wasn't a
13 requirement. But a lot of them, the multidisciplinary
14 team said it enhanced the patient's quality of life,
15 and so it would, if you have your one-to-one and you 12:21
16 can go out and about. So there was additional staff
17 come onto the wards. The patient had his own staff
18 member. But I think it actually slowed up the
19 discharge, because it made them a very complex
20 discharge. Whereas this person maybe never had a 12:21
21 one-to-one. It was for their protection at the start
22 if they maybe might have been assaulted by another
23 patient, or they may have assaulted someone else, but
24 it never seemed to end. And I was constantly going
25 into it, and if I questioned it, I would have been 12:21
26 questioning saying 'Well, are you going to take the
27 risk if something happens to the patient or another
28 patient?', so it just carried on.
29 DR. MAXWELL: We've heard other people suggest there

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1 were negative impacts of this, so it limited your staff
2 to do other things.
3 A. Mmm.
4 DR. MAXWELL: But also some people have suggested that
5 some patients didn't find it particularly helpful to 12:22
6 have somebody with them at all times. It may have
7 increased their distressed behaviours --
8 A. Yes, some -- but, yeah, that's right too to an extent,
9 but usually it enhanced the staff -- most of the
10 patients that were put on it, their quality of life 12:22
11 probably did improve, they got out and about a lot
12 more, they had their staff to go on to day care with
13 them. The people that were higher dependency, so it
14 would be. It depends on the reason for the
15 safeguarding. If it was within the forensic unit and 12:22
16 there was issues around risk for other patients, yeah,
17 you would have found some of the less dependent
18 patients would be opposed to it, they would want off it
19 all the time, because obviously they can't get moving
20 around the ward and they've a staff with them all the 12:23
21 time. But the high dependency patients who would need
22 a lot of support, it probably enhanced their quality of
23 life. A small number maybe.
24 DR. MAXWELL: So it was mixed?
25 A. Yeah. 12:23
26 CHAIRPERSON: But did anybody put forward the argument
27 at MDT that if you give a patient one-to-one care for a
28 long period, it's going to make them much less
29 self-reliant.

1 A. Yeah. Well, I did. Absolutely. Yeah, I did.
2 CHAIRPERSON: Yes.
3 A. But it just didn't change. Nobody was willing to take
4 the risk of dropping it.
5 CHAIRPERSON: And how often were these patients who 12:23
6 were on one-to-one being reviewed? How often was that
7 --
8 A. Practically weekly. When they went off to
9 safeguarding, their one-to-ones were reviewed weekly
10 with a multidisciplinary team, but it just turned into 12:23
11 a paper exercise. It just never stopped.
12 PROFESSOR MURPHY: Given so many of these patients were
13 delayed discharge patients, do you not find it
14 surprising that they were engaging in very high rates
15 of patient-on-patient assaults? 12:24
16 A. Well --
17 PROFESSOR MURPHY: You know, does it imply that you're
18 ready for discharge? Probably not? Were they getting
19 behavioural plans? Were they being supported by PBS
20 care plans, you know? 12:24
21 A. They were, but they were delayed discharge, and many of
22 them, their aggression was down to sheer frustration,
23 and anxiety too, because some of them were waiting for
24 a year, and nothing definite that they would be
25 discharged in a year. They didn't require to be there. 12:24
26 Then people who were coming into the ward were very
27 disturbed, for a short period of time, and that made it
28 unsettling for them. So their anger was quite
29 justifiable many times. That bit was maybe looked at.

1 It was sheer frustration.
2
3 They also, particularly people with very complex
4 autism, they would have got used to a patient group on
5 the ward, and maybe some of them started to move on and 12:25
6 then other people were coming in, changes just in
7 staffing in them areas. It was just a very frustrating
8 time for them. So if I was waiting for a year to get
9 out of hospital it would be very, very difficult for me
10 to deal with, and them triggers were never looked at. 12:25
11 They were just really frustrated. And that didn't
12 matter what level of dependency or intellectual
13 disability you had. They knew it was hopeless. And it
14 was hurt, it was hurting to watch relatives that were
15 fit to take these people home on a Friday and bring 12:25
16 them back on a Monday, and we had them on a one-to-one
17 during the week, and maybe all it was that they hadn't
18 got a day service or they hadn't got a roof over their
19 head. Do you know? Like we can find accommodation for
20 lots of people coming to live in Northern Ireland at a 12:26
21 drop of a hat, so why can't we find it for people with
22 a learning disability and put that support there.
23 DR. MAXWELL: So are you suggesting that the increase
24 in safeguarding incidents could be as a result of
25 failure to resettle people. 12:26
26 A. Absolutely, it is. Sheer frustration, and anger, and
27 anxiety. That circle went round and round, and so many
28 people I could give you examples of them in that list
29 that I would have felt got worse, particularly the

1 people who were in their individual areas. They may
2 not have been close to other patients. But, you know,
3 just to -- you know, a young man or woman at 18 or 19,
4 to be in an apartment on their own with two staff and a
5 uniform, what's normal about that? And maybe then that 12:26
6 makes their discharge more difficult because they're
7 asked to have -- "I have to have", "Oh, they can't be
8 discharged to such and such a unit unless they have one
9 staff 24-hours a day", or two, or maybe three. So what
10 voluntary or private organisation is going to reduce 12:27
11 that once they go?
12 CHAIRPERSON: Mr. McEvoy.
13 168 Q. MR. McEVOY: Okay. So, Mr. Mills, you say then at
14 paragraph 55, to you the hospital truly changed from
15 around 2014 to 2016. 12:27
16 A. Mhm-mhm.
17 169 Q. "The staff, patients, and relatives became frustrated",
18 which you have just described.
19
20 "The hospital was at such a low I felt that I could not 12:27
21 do anything."
22
23 You had planned to retire, you say, in October '17, but
24 you didn't due to things arising from the CCTV footage.
25 You decided to stay on and see it through. 12:27
26
27 "The staff would do things in their own time and go
28 above and beyond."
29

1 You have had to go on to wards sometimes to tell Ward
2 Managers to go home because they had worked way past
3 their finishing time.
4
5 "It would not have been unusual for Staff Nurses or 12:27
6 Ward Managers to stay a few hours after a shift ended."
7
8 Can you be a bit more specific for us and tell us why
9 you think the hospital changed between 2014 and 2016?
10 A. Just with frustration with resettlement, they not 12:28
11 knowing how many patients they're going to have in the
12 new hospital, they didn't know what future they had,
13 particularly the resettlement people being moved from
14 ward to ward. The temporary staff that I had that were
15 coming up to four years, they didn't know, or two or 12:28
16 three years in temporary posts, they didn't know how
17 long they were going to have a job for. Was this going
18 to be a career for them? No promotion. Anybody was
19 put in post into a Deputy Ward Manager post they maybe
20 went for years in that post, Band 7 posts, and 12:28
21 temporary posts, and then we hit 2015/16, people
22 decided then that there was an opportunity to go to do
23 health visiting.
24 170 Q. Yes.
25 A. Behavioural. No -- they were never coming back to us. 12:28
26 And as soon as they walked out of their temporary post,
27 they would have stayed and took a permanent post either
28 at Band 7 or 6, and as soon as the day they went out,
29 there was an advertisement for permanent replacement

1 for them! Now them people left thinking they were
2 undervalued, because nobody is going to come back after
3 a health visiting course to Muckamore after that.
4 171 Q. At paragraph 57, you talk about how, in the core
5 hospital, patients were being admitted and the patient 12:29
6 profile did not allocate presumably the patient to a
7 ward, so the admission had a mix of high and low
8 dependency patients with range of mental and physical
9 needs:
10 12:29
11 "This was not what the hospital was designed for. Some
12 patients would come to the hospital and be immediately
13 referred to the Antrim Area Hospital due to their
14 medical needs."
15 12:29
16 A. Yes.
17 172 Q. Is that to be read as meaning, Mr. Mills, that wards
18 had mixed ability and mixed dependency, patients who
19 didn't belong together?
20 A. You wouldn't normally have put those groups together, 12:29
21 no. The other -- when Muckamore was larger, you would
22 have had -- you could have had particular dependency
23 levels, intellectual disability, could have been much
24 suited to one area working in them, whereas it was a
25 mixture of everyone. And that would have been fine, we 12:30
26 could have managed that if people were coming for six
27 to eight weeks, but once they become delayed discharges
28 -- some of these people were becoming delayed
29 discharges after two or three weeks. It just made it

1 very unsettled.
2 173 Q. So why was that being done? Why was this mix of
3 patients and abilities and dependencies taking place?
4 A. We were designed to be able to manage that acute -- we
5 had single rooms, we had day spaces, and that's fine 12:30
6 for short periods of time. You could manage that for
7 maybe --
8 174 Q. How long, for example?
9 A. Six to eight weeks. Two months. That's what it was
10 designed for. 12:30
11 175 Q. Yes.
12 A. But if you've people with different abilities,
13 different care needs going for a long period of time.
14 And also we mentioned there medical needs. Some of the
15 patients were being admitted and chronic chest 12:30
16 infections, physical, poor health care in the
17 community, not necessarily at Muckamore, but they
18 weren't coming for better health care in Muckamore.
19 They had to go to Antrim Area Hospital for that. And
20 what surprised me more than anything, and this was 12:31
21 coming in from 2014 and our staffing requirements, was
22 when them patients went there, our staff had to stay
23 with them.
24 176 Q. Okay.
25 A. So that was a big loss. And our medical staff 12:31
26 certainly weren't trained to deal with it.
27 177 Q. Can I touch just on the opening sentence of the next
28 paragraph then, and maybe you can help us, it has just
29 caused us a little bit of confusion, but I'll read it

1 out:
2
3 "When the core hospital opened in 2006, very few
4 patients in PICU and the Cranfield Mens Ward also
5 managed the PICU, so it was only enhanced by staff when 12:31
6 required."
7
8 There's maybe something which has been missed in the
9 statement taking process, but can you explain what it
10 is that you mean? 12:31
11 A. When Cranfield opened first, PICU would be used for
12 very complex admissions or, indeed, if there was a
13 deterioration -- the type of patients that we --
14 178 Q. Can you slow down a wee bit.
15 A. Say, for instance, the patients with very complex 12:32
16 autistic spectrum, and the ones that -- some of the
17 difficulties that we were just talking about there, we
18 were seeing with a mix of patients. They may have
19 required to go to the ICU or higher staffing levels in
20 it. We had much higher staffing levels if they had 12:32
21 come maybe one-to-one or two-to-one in that area. Now
22 we had a Band 6 there, but that was managed directly
23 from Cranfield Mens. But for the first year or so, we
24 had very very few admissions to it. We would have sat
25 with about 50% capacity. 12:32
26 DR. MAXWELL: So are you saying that PICU wasn't open
27 all the time? You flexed it when you had patients.
28 A. Yeah.
29 DR. MAXWELL: You had staff who worked primarily on

1 Cranfield, and when you needed to open the PICU beds,
2 you did, and staff did it, and then when the patient
3 left you closed those beds.
4 A. Yes.
5 179 Q. MR. McEVOY: I'd like to move on, if I could Mr. Mills, 12:33
6 to paragraph 66, which is on page 19. And this is
7 about staff training, particularly in and around MAPA
8 and related types of requirements. So here you say:
9
10 "One of the things you were concerned about was 12:33
11 training of staff and keeping this training
12 up-to-date."
13
14 However, two areas of concern that you had. The first
15 being for new staff, the first training induction they 12:33
16 get is physical training on MAPA.
17
18 "Although an excellent programme, it is more concerned
19 with physical intervention. So the first training they
20 go through is the physical side of dealing with 12:33
21 patients. Secondly, because of staff shortages we had
22 to combine fire training and personal relationship
23 training sessions. These sessions were in addition to
24 the MAPA training. So almost all of my behavioural
25 team..." 12:34
26
27 - you say:
28
29 "...were the trainers of MAPA. I never went on to a

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1 ward and saw something being done incorrectly.
2 Another concern I had was that changes in seclusion and
3 the recording of seclusion. The Charge Nurse of the
4 PICU and Service Manager agreed the implementation of
5 an electronic system to record seclusion. The person 12:34
6 observing seclusion had to record their observations
7 afterwards on the electronic system, and this may not
8 have been done by the person observing the seclusion.
9 It could only be an accurate record if it was recorded
10 as you were observing seclusion and the times may not 12:34
11 have been accurately recorded."
12
13 So pausing there. Was the effect of what you say there
14 about that recording of seclusion, that when a patient
15 was being held in seclusion, it wasn't being properly 12:35
16 recorded, or that seclusion was not being recorded at
17 all as and when it happened?
18 A. Not being properly. So that I wouldn't have had any
19 evidence at that stage that it wasn't being recorded.
20 180 Q. Yes. 12:35
21 A. But my concerns at that stage was that it wasn't being
22 accurately recorded, because you really would have
23 needed an iPad to have recorded that, so that some way
24 to transfer that immediately onto the electronic
25 system. 12:35
26 181 Q. Yes.
27 A. Whereas they were still making it in note form. And
28 then that could have been -- and that put into the
29 office and that recorded by a Staff Nurse later on in

1 the day, and I'm not just so sure how accurate that
2 could have been. The staff on the ward and the Ward
3 Managers assured me that it was being done, and I could
4 see it in the system, the times, but subsequently as we
5 started to look at the CCTV they weren't being recorded 12:35
6 accurately, there was times out, they weren't the right
7 times on them, and it just concerned me whether the
8 staff hadn't got the training even for the recording of
9 it accurately. But the written record of it may not
10 have been done right. 12:36
11 DR. MAXWELL: Can I just ask about that? So originally
12 there would have been paper records of seclusion?
13 A. Mhm-mhm.
14 DR. MAXWELL: And you say that your concern happened
15 when the electronic system was introduced, which I 12:36
16 presume is PARIS?
17 A. Yes.
18 DR. MAXWELL: Are we talking about PARIS?
19 A. No, it was -- PARIS, yes, came out, yeah. But then
20 there was a separate seclusion care plan within PARIS. 12:36
21 DR. MAXWELL: Within PARIS. But we've also heard from
22 other people that healthcare assistants weren't allowed
23 to directly enter on to PARIS.
24 A. That's right.
25 DR. MAXWELL: It was registered nurses. So are you 12:36
26 saying that sometimes healthcare assistants were doing
27 the observation of seclusion?
28 A. Yes.
29 DR. MAXWELL: But because of the hospital policy on

1 PARIS, they couldn't enter their observations, they had
2 to tell a third party, a registered nurse? So this was
3 an unforeseen consequence of moving to PARIS?
4 A. Yes.
5 DR. MAXWELL: And that potentially that's why it wasn't 12:37
6 a full and complete record?
7 A. Yeah. I just was uncomfortable with it. I would have
8 much preferred the healthcare assistant's written
9 record to be failed and kept with it, as that was
10 accurate. Whereas they were -- I had no control over 12:37
11 whether they were recording the observation correctly,
12 was it word-for-word from what the nursing assistant,
13 or the Staff Nurse at that time where they went and
14 done it, was it accurately recorded? But they seemed
15 confident at that time it was okay. 12:37
16 DR. MAXWELL: So were the healthcare assistants writing
17 it and those records were not retained?
18 A. Yeah. I think so, yeah.
19 CHAIRPERSON: The actual seclusion has to be authorised
20 by a nurse? 12:37
21 A. Yes.
22 CHAIRPERSON: So the beginning of the seclusion ought
23 to be going on to PARIS.
24 A. Mhm-mhm.
25 CHAIRPERSON: But if a healthcare assistant is then in 12:38
26 charge of the observation, those observations might not
27 be getting on to PARIS.
28 A. No.
29 CHAIRPERSON: But who authorises the end of the

1 seclusion?
2 A. Trained staff.
3 CHAIRPERSON: Sorry?
4 A. The trained qualified nurse has to --
5 CHAIRPERSON: Right. So that also ought to be on 12:38
6 PARIS. It's the bit in the middle that may be lacking.
7 A. Yes.
8 CHAIRPERSON: Right.
9 182 Q. MR. McEVOY: Just before we leave paragraph 66, can I
10 just ask you one point about the MAPA training, 12:38
11 Mr. Mills? Would you say that de-escalation skills --
12 I suppose I am asking for your opinion, but it would be
13 helpful nonetheless -- de-escalation skills aren't a
14 prominent part of MAPA training?
15 A. On paper it is, but I was a trainer in care and 12:38
16 responsibility in the '90s.
17 183 Q. Which was the previous system?
18 A. Yes.
19 184 Q. Yes.
20 A. And the physical components, that would stay in your 12:39
21 mind, and if it's your first week of training into the
22 hospital, and if it's role play, and physical, that
23 will be the bits that will stay there with you. I
24 think you get away from it, when you walk away at the
25 end of the week. When you start to combine that with 12:39
26 some elements of the behavioural approach, and then we
27 have our mandatory training that was coming in, where I
28 would have brought in the TILII Group to speak to them,
29 I'm not just sure what they would have took away from

1 that first week. And then they seen behavioural nurses
2 as the trainers for this technique. So they assumed
3 that both physical intervention is all part of the
4 behavioural approach, and it may well be, but I do
5 think that that's what they went away with, that vision 12:39
6 in their head.
7 185 Q. Looking across to paragraph 73 then on page 22, you
8 pick up on seclusion again as a topic. Here you say:
9
10 "There would sometimes have been an increase in 12:40
11 seclusion with a particular patient. There would have
12 been an MDT meeting that would take place and I would
13 review notes. The co-director may have asked me at the
14 meeting had there been any changes in medication which
15 would result in an increase in restraint or physical 12:40
16 interaction needing to be utilised. After these
17 meetings I would have noticed a gradual reduction in
18 restraint and seclusion."
19
20 You then go on to give the example of one patient, P60, 12:40
21 who was a patient within PICU who was later transferred
22 to Six Mile and a delayed discharge, and there you
23 noticed a pattern in his behaviour in that his mental
24 health had deteriorated and he had become aggressive
25 and needed an increased use of seclusion and physical 12:40
26 restraint. Over time, you say that:
27
28 "...the need for these would gradually reduce and
29 become almost zero. But with this particular patient,

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1 P60, it was like a cycle. He seemed ready for
2 discharge but then he would have become aggressive
3 again. He was recommended to go to a medium secure
4 unit in England, but the family opposed this. This
5 kind of unit would have had an increased number of 12:41
6 staff compared to Muckamore. When we transferred
7 patients over to these medium secure centres, the
8 outcomes were successful. Muckamore is a learning
9 disability hospital and would not have the resources
10 available in medium secure service." 12:41
11
12 Now, in a situation whereby an MDT identifies patterns
13 resulting from the use of seclusion, and after an MDT
14 the use of seclusion reduces, can the Inquiry take it
15 that that is another way of saying that in fact there 12:41
16 was overuse potentially of seclusion prior to the MDT?
17 Do you follow me?
18 A. No, I wouldn't say it was an overuse of it. It's the
19 time to take stock of their interventions and how
20 they're -- and it may have been a change in medication, 12:42
21 it could be another behavioural approach to the
22 patient. But we would have seen a reduction in it.
23 And quite often. But there could have been a number of
24 factors that would have led to that reduction. It
25 could have been maybe even moving -- it could have been 12:42
26 another patient, actually, moving out of a ward could
27 have been a link to it as well.
28
29 When you seen the seclusion records going up, or even

1 physical intervention, that's sort of an alert to you
2 as well to review actively what's going on with this
3 patient. But that particular patient was, it was felt
4 very early on in his admission that a medium secure
5 unit would have been much more beneficial to him. 12:42
6 186 Q. At 74 and 75 then, you talk about allocation sheets and
7 their use and implementation.
8
9 "All wards had an allocation sheet and depending on the
10 ward, staff might have been allocated to a care group 12:43
11 made up a minimum of three patients. This would have
12 involved washing, cleaning, and being responsible for
13 their overall care. The nurse in charge was on the
14 allocation sheet."
15 12:43
16 In your ward there would have been an allocated
17 response team which would deal with the alarm system.
18
19 "The team would respond if an alarm went off, where
20 someone, for example, had fallen and the staff needed 12:43
21 assistance to get them up.
22
23 In Cranfield 1, Cranfield 2, and the ICU, the alarm
24 would have went and then that response team would go to
25 that ward to help. These were designated people who 12:43
26 would respond, and with the CCTV viewing..."
27
28 - you say you're not sure if the system was being used
29 correctly.

1 A. Yes.
2 187 Q.
3 "It seemed that when the alarm went off a couple of
4 staff would have went off and helped. I'm not sure if
5 the system is being used correctly. It seemed that 12:44
6 when an alarm went off a couple would respond. You
7 liked to ask staff if they know the system was in
8 place."
9
10 One of the checks you carried out was when you went on 12:44
11 to the ward to ensure that the batteries were working
12 correctly.
13
14 You say then say that:
15 12:44
16 "One of the items on the allocation sheet was making
17 sure staff were assigned to patients on higher
18 observation levels, like one-to-one..."
19
20 - which we discussed. 12:44
21
22 "...and that staff members should not have been doing
23 any more than two hours of this."
24
25 A concern you express is that between 2015 and '17 was 12:44
26 that patients were being put on a higher level of
27 observations.
28
29 "The staff were burning out as they had to do two hours

1 of high level observations, then carry out an activity
2 with patients, and then another two hours of high level
3 observations without a break."
4
5 You noticed that staff were bored and patients were 12:44
6 bored. It was a vicious circle.
7
8 "I believe this is one of the reasons for high
9 aggression on the wards."
10 12:45
11 So, was it a Trust policy that staff should have a
12 break from enhanced supervision for two hours?
13 A. You shouldn't do it any longer than two hours at a
14 time, yeah.
15 188 Q. All right. 12:45
16 DR. MAXWELL: You seem to be implying that that was --
17 that they should then take a break and not move to
18 another activity?
19 A. Mhm-mhm. They did, they took a break.
20 DR. MAXWELL: Is that what the policy said? 12:45
21 A. And then they went back -- or it could have been they
22 went another hour or two of their shift doing something
23 with a group of patients, and then maybe went back on
24 to the two hours again. But they had to have a break.
25 But then you could have -- in a 12-hour shift you could 12:45
26 have ended up maybe for half of that there with breaks
27 in between it with doing two, two-hour -- three
28 two-hour stints of constant Level 1 obs.
29 DR. MAXWELL: So are you saying practice on the wards

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1 at this time was outside the Trust policy?
2 A. It wasn't, it was actually within it, but it was just
3 so -- because there was so many patients. The policy
4 was devised for having very few patients on that level
5 of obs, or certainly within Muckamore. I never 12:46
6 envisaged that we would have just as many patients.
7 Safeguarding, it was just so many, and we thought you
8 might have had one shift of two hours, if you had five
9 or six staff on, but when you had that numbers you were
10 just revolving round and round each day. 12:46
11 CHAIRPERSON: So the definition of a break was not...
12 A. Not having a cup of tea or anything, no.
13 CHAIRPERSON: ...go and have a cup of tea. It was go
14 and do something else?
15 A. That's exactly it. 12:46
16 CHAIRPERSON: Okay. Thank you.
17 189 Q. MR. McEVOY: So would an effect of that practice, that
18 policy, have been then that not leaving the ward so
19 much for other day care activities, it became, as you
20 say, a vicious circle of boredom, inactivity, 12:46
21 heightened aggression as a result. Is that the
22 consequence?
23 A. Yes.
24 DR. MAXWELL: So are you saying that staff then were
25 getting burnt out and their behaviours were becoming 12:47
26 more risky?
27 A. Yeah, in hindsight, yeah, no, I do. I seen it -- from
28 what I observed on the CCTV, I just seen people that
29 were absolutely burnt out, and patients too, because

1 they were in hospital for so long, and just -- it was
2 -- that would have been a difficult shift if you were
3 in a very challenging unit for a day if you were doing
4 Level 3 obs or at arms length. And we did touch on the
5 alarms system, which concerned me more that people 12:47
6 weren't using the alarm system correctly. They should
7 have a response team, and the alarm system that they
8 have in Muckamore, I don't know if they have it now,
9 but one was just for assistance, if you were in the
10 room that we talked about. The other one was a 12:47
11 response team. And my observations wasn't -- the
12 response teams weren't using the delegated people that
13 were on the sheet, and that could cause problems. It
14 could make a situation even worse if you were
15 responding to ICU, or you could have just everybody 12:48
16 running, because the emergency response, there was an
17 alarm in the back, and you don't hear that on CCTV. I
18 know that because -- you could have had a big number of
19 people running in, running in blind. Where the whole
20 idea of the alarm system was that you would have had 12:48
21 four people maximum going to that area, and the person
22 that was in ICU would have been in the lead, but that
23 didn't --
24 CHAIRPERSON: But isn't that a question of training?
25 A. It was in the training. It was a part of the training, 12:48
26 yeah. But people were just -- whether they changed
27 over or what, they just weren't sticking to it, what I
28 noticed.
29 CHAIRPERSON: So -- sorry.

1 DR. MAXWELL: But you were the manager at the time.
2 A. But I only picked it up when we got vision of the CCTV.
3 I hadn't seen that.
4 DR. MAXWELL: So you didn't know at the time they were
5 doing that -- 12:48
6 A. I assume when I come these were the people that were
7 delegated if it did go, you know. Or there was another
8 alarm came on. But I was looking at the CCTV and I
9 could see maybe eight staff just heading in towards
10 ICU. So there was no co-ordination of it, and they 12:48
11 should know that.
12 CHAIRPERSON: Who should have spotted that on the ward?
13 Who should have seen that and stopped?
14 A. Nurse in Charge should have noticed. There was far too
15 many staff leaving the ward. It was leaving the one 12:49
16 ward unsafe. Or if they didn't turn up, the Nurse in
17 Charge of ICU, you know. Because equally what could
18 have happened, if they weren't sticking to the
19 allocation sheet, it could have resulted in nobody
20 responding to the alarm. And there also was -- that 12:49
21 was one of my reasons about why we should have had a
22 lot more of an opportunity to be able to review CCTV,
23 not just for safeguarding, because you could learn an
24 awful lo from incidents, you would have picked that up
25 very early on. 12:49
26 DR. MAXWELL: So the Ward Manager should have been on
27 top of whether people were following policy?
28 A. Mhm-mhm. Or that people were responding to it.
29 190 Q. MR. McEVOY: Paragraph 76 then, Mr. Mills, you tell us

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1 that you felt supported in your role, things were
2 difficult -- you did feel things were difficult from
3 2014 to '16.
4
5 "This was due to the closure of wards and moving 12:50
6 patients and staff out into other areas within the
7 hospital and outside."
8
9 You identify that:
10 12:50
11 "The closure of Hillcrest Housing Development made
12 things difficult..."
13
14 - and you voiced concerns about that to H507, and
15 Mr. Veitch, the co-director, about staffing levels. 12:50
16 You do say that you never felt animosity from them and
17 felt comfortable, but you did not see any change about
18 the concerns that you raised.
19
20 You reiterate that there was a focus on delayed 12:50
21 discharge which affected staff on the ground. Staff
22 were not anticipating the amount of patients coming in
23 nor the amount of children from Iveagh:
24
25 "We were getting an increased number of patients and 12:50
26 more patients with complex needs. Decisions were made
27 for the secondment of staff to do a health visiting
28 course and I knew we would never get these staff back.
29 I could not replace these staff and had to get

1 temporary staff as the seconded staff were still under
2 contract at the hospital and could come back if they
3 wanted, but no-one was going to come back. We also
4 seconded 10 Staff Nurses to the specialist practice
5 course, which was behavioural focused, and I had to 12:51
6 replace these staff with temporary staff, and I didn't
7 have the staff to replace these people. I think one
8 might have stayed on when returning from the seconded
9 role, but they did not join in a specialist role as it
10 was not available at Muckamore. 12:51
11
12 I had concerns about who I was supposed to be reporting
13 to with my concerns. I felt that when I raised things
14 it was listened to at times, but I did not see a lot of
15 change. I had supervision on a regular basis and it 12:51
16 was positive towards me."
17
18 On the point, Mr. Mills, about the 10 staff seconded to
19 undertake specialist practice in behaviour management,
20 do you recall whether a business case was put forward 12:51
21 to fund specialist nurse posts?
22 A. No.
23 191 Q. Okay. Is that, no, you don't recall, or, no, there
24 wasn't one put forward?
25 A. I don't recall. There was nothing... 12:52
26 DR. MAXWELL: But if you are sending people to
27 specialist course, a specialist post will be a higher
28 grade.
29 A. Yes.

1 DR. MAXWELL: Did you not...
2 A. I questioned it, yeah.
3 DR. MAXWELL: You would question it and say 'How are
4 they going to work when they come back?'.
5 A. I was told that it would be for the development of 12:52
6 community services, Learning Disability Services
7 throughout Northern Ireland. If we lost them, well
8 that would only -- it would mean that we'd have less
9 admissions to the hospital. That's what I was told.
10 DR. MAXWELL: So you always assumed these staff were 12:52
11 going to work in the community and not come back and --
12 A. I didn't, I was told that. If they wanted to work in
13 Muckamore with enhanced training, well, why would they
14 at a Band 5? But it was no advantage to me. It was
15 like it was for the betterment of Learning Disability 12:52
16 Services throughout Northern Ireland.
17 DR. MAXWELL: Okay.
18 192 Q. MR. McEVOY: You recall at 77 you had weekly managers
19 meetings with the Service Manager up until 2015 and
20 '16, and in that time you had five senior managers. 12:52
21 Prior to 2012 you had a structured meeting every Monday
22 discussing patient incidents, but after that these were
23 not always on a Monday. They did take place weekly.
24 And you give a reason from H507 that she couldn't
25 manage a meeting every Monday because of her other 12:53
26 roles within the community and outside the hospital.
27
28 You say then in the next paragraph, 78, you would have
29 seen Directors and the Chief Executive on site on an ad

1 hoc basis, and the last one to meet you was Pat McCart.
2 After Pat McCart left you didn't see a Non-Executive
3 Director on site until 2017. And the disclosures about
4 abuse. You would have seen Michael McBride, Martin
5 Dillon, and Colm Donaghy, who would have arrived 12:53
6 informally. Pat McCart in that Non-Executive role had
7 met with the TILII Group at their request and he would
8 have spoken directly with you and other staff and
9 patients, but in latter years that didn't happen:
10 12:54
11 "With other pressure in the Belfast Trust and staffing
12 issues the Royal Victoria Hospital..."
13
14 - there were other issues going on, but you don't feel
15 that Muckamore was a priority to them. 12:54
16
17 Can you recall approximately when it was, even in terms
18 of year, when it was that you met Pat McCart for the
19 first time?
20 A. The very first time I met Pat McCart? 12:54
21 193 Q. Yes?
22 A. Oh! This would have been not long after the new units
23 opened, around 2008 maybe now, or before it, but I
24 can't remember. I think the last time it would have
25 been around 2013/14 when he left. I think he was 12:54
26 Chairman on the Belfast Trust as well.
27 194 Q. So you would have seen him about 2008 for the first
28 time and then the last time in around 2014, is that
29 your evidence?

1 A. Or even earlier than that from his time. He would have
2 been a regular visitor, very informally, in the
3 hospital. But what he did do, and I wouldn't have
4 known he was on site, he would have met with the TILII
5 Group. The TILII Group would have -- 12:55
6 195 Q. Yes, indeed, you've said that. Yeah.
7 A. I wouldn't have known he'd been there.
8 CHAIRPERSON: But the real point is from 2014 to about
9 2017, you did not see a Non-Exec Director on site?
10 A. Never seen -- no, I never come across one. 12:55
11 196 Q. MR. McEVOY: Yes. All right. Now, in the following
12 paragraphs then there's more discussion helpfully from
13 you around the issue of resettlement and you describe
14 how the TILII, which as we discussed earlier in your
15 evidence, how the TILII Group stopped meeting with the 12:55
16 senior management team, and again you describe your own
17 physical moves in terms of location around the hospital
18 campus.
19
20 You say at 81 that you absolutely felt you could speak 12:55
21 about or report anything about which you were
22 uncomfortable. This does not mean that anything was
23 changed when you did this. Can you tell us what you
24 mean by that?
25 A. Just really about the staffing levels in the hospital, 12:56
26 or plans for the future. I was just a bit worried
27 about -- and the way things that would have happened,
28 you know, I always wanted the CCTV and that, and it
29 just happened overnight, it just came out of a meeting

1 and was told it happened, and I had no formal
2 discussions at operational level about the CCTV, the
3 closure of Cranfield Womens' Ward to transfer over to
4 Killead, to Killead back over to Cranfield 1, that
5 become Cranfield Mens' 1 and 2. That was to do with 12:56
6 bed pressures. But it was informal. It was actually
7 discussions just at a meeting around it. I've never
8 got time to put pen to paper.
9 197 Q. Yes.
10 A. I went on holidays and came back and it was to happen. 12:56
11 Some people we discussed it, and it was very badly
12 planned. So I was a bit reluctant in it. But staffing
13 and issues like that and other things, nothing seemed
14 to make any difference to it. It was all budget led.
15 198 Q. You say then in the next paragraph, you had no more 12:57
16 complaints than what you've covered within the
17 statement. If you had an issue with the Ward Manager
18 you would have gone to your line manager, H507, and did
19 you did that. If you had concerns with your Service
20 Manager you felt comfortable to speak to Mr. Veitch, 12:57
21 and you spoke to him a few times, not formally, but
22 discussions about that did become more formal. What
23 made those discussions become more formal, Mr. Mills?
24 A. I was just concerned about the direction that we were
25 following, and I found difficulty in whether who or 12:57
26 what director that we were working under? Was it
27 social and primary care, were we under the directorate
28 of corporate nursing?
29 199 Q. Yes.

1 A. You know, what developments was coming? Because I did
2 sit on the recruitment group, which was part of the
3 corporate nursing, but I just -- it was very difficult
4 to know what or who we were reporting to, and they
5 stuck very rigidly to a line management process. I 12:58
6 would never have, in my wildest dreams, have thought of
7 going to speak to a director.
8 200 Q. You do then say though that:
9
10 "If I needed to raise an issue outside the hospital I 12:58
11 would have raised the issue with Mr. Veitch, but there
12 were times I wondered if it would have been better to
13 go to the co-director of nursing, but the roles changed
14 so much during this time."
15 12:58
16 Why did you wonder that?
17 A. Because it was nursing staffing numbers that I had my
18 concerns with.
19 201 Q. Right.
20 A. But technically I should haven't had to do that. I 12:58
21 would have went to the Associate Director of Nursing,
22 and that was -- it was my Service Manager.
23 202 Q. Yes.
24 A. That's who I would be talking about the nursing issues,
25 and relied on her to transfer that through to the 12:58
26 nursing side of things. But I don't remember having
27 any formal discussions with co-directors of nursing.
28 203 Q. Can I then ask you -- just looking across to...
29 CHAIRPERSON: Well, sorry just to pause for a moment.

1 It's 1:10. Sorry, looking at the statement, you've got
2 quite a way to go.
3 MR. McEVOY: Yes.
4 CHAIRPERSON: I would say at least half an hour.
5 MR. McEVOY: I would have thought half an hour, yeah. 12:59
6 CHAIRPERSON: Yes. I think that -- and then you've got
7 the restricted part to deal with. Much as we want to
8 get through this witness' evidence, we will do it
9 today, but I don't think it's fair on the stenographer,
10 who is working at double speed, if I may say so. So I 12:59
11 think we will take a slightly shorter lunch break. So
12 we'll try come back at 2:00 o'clock. But we mustn't
13 rush this evidence.
14
15 I'm aware we've got another witness coming and we'll 12:59
16 just see how far we can get with that witness. All
17 right.
18
19 So, thank you very much. We'll see you back at 2:00
20 o'clock. All right. 12:59
21
22 LUNCHEON ADJOURNMENT
23
24 THE INQUIRY RESUMED AFTER THE LUNCH ADJOURNMENT AS
25 FOLLOWS: 13:52
26
27 CHAIRPERSON: Thank you.
28 204 Q. MR. McEVOY: If I can take you to paragraph 85 then,
29 please, on page 27? There is a question here around

1 the topic of admissions, and admissions out of the
2 hospital, and in particular to Antrim Area Hospital,
3 and here you say:
4
5 "Staff did not know about a lot of admissions until 13:53
6 they were admitted into the ward. Detained admissions
7 became voluntary admissions over a short period and
8 would be stuck in the hospital. What concerned me was
9 the physical conditions of patients upon arrival to the
10 hospital and they may have had to be transferred to the 13:54
11 Antrim Area Hospital soon after arrival. They may have
12 arrived with chest infections..."
13
14 - which I think is something you said in your evidence
15 this morning: 13:54
16
17 "...for example, and they did not develop this at
18 Muckamore, they arrived with it. When these patients
19 went to Antrim, the Muckamore staff had to stay with
20 them 24/7." 13:54
21
22 Can you comment on whether this risk of staff having to
23 stay with patients 24/7 if they went to Antrim might
24 have led to a reluctance to refer patients across to
25 Antrim? 13:54
26 A. No. Definitely not.
27 205 Q. That's not something that would have happened?
28 A. No. Definitely not.
29 206 Q. Okay. There mightn't have been any incentive or

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1 disincentive if there was a possibility that you were
2 going to lose a member of staff?
3 A. No. Yeah, it would have caused problems, but that
4 would have been the priority, especially if any of the
5 medical staff had of been -- if this was an assessment 13:55
6 on admission, they would have been referral to go to
7 Antrim Area Hospital for assessment. And, no, I have
8 never come across that.
9 207 Q. Pull the microphone a wee bit closer.
10 CHAIRPERSON: Can you keep your voice up? Yes. Sorry, 13:55
11 I've lost you a little bit.
12 208 Q. MR. McEVOY: Okay. All right. That's perfect where
13 you are. That's where you were earlier. Okay. All
14 right. And then can I ask you then about the question
15 of care plans, and in particular around the 13:55
16 digitisation of care plans.
17 CHAIRPERSON: So this is 88.
18 209 Q. MR. McEVOY: This is paragraph 88 at the bottom of page
19 27. So you've indicated that you weren't involved in
20 the area of developing care plans for patients? 13:55
21 A. No.
22 210 Q. You indicated that it would have been better if you
23 had. You were involved in a large group consultation,
24 but not in the development of care plans, and then on
25 digitisation, you say at 88: 13:56
26
27 "There were digitalised care plans which were fairly
28 formal, but the old written care plans were more
29 personalised. Digital care plans are hard to scan, for

1 example, seclusion and MDT information."
2
3 You describe how you found it difficult to comprehend
4 at times, but relatives didn't complain.
5 13:56
6 "When the digitalised care plans were printed it was
7 not patient friendly at all, and in the early 2000s I
8 was working on an individual care plan idea..."
9
10 - you say: 13:56
11
12 "...that would go with the patient everywhere, even
13 when discharged and upon readmission to Muckamore, if
14 necessary, but this never came to be."
15 13:56
16 Do you know, although you might have had more limited
17 input, do you know what input senior nurses at
18 Muckamore had into the design of those records?
19 A. Very little. There was a working group of Staff Nurses
20 and Ward Sisters in it, but the digitalisation of it 13:56
21 was still very much left with the resource nurse and it
22 seemed almost like a regional group was looking at the
23 digitalised. The nursing staff that were involved, and
24 the working group in the hospital, they were of the
25 firm belief that they were transferring the same format 13:57
26 as their nursing care plan, the old written notes.
27 211 Q. Yes.
28 A. But it actually was being developed to be a
29 multidisciplinary care plan.

1 212 Q. Yes.
2 A. Which, again, I don't believe truly materialised as a
3 multidisciplinary care plan, because social workers
4 kept their notes, the medical staff still kept their
5 medical notes, psychology still had their notes, they 13:57
6 still recorded in them, the day care staff recorded in
7 the digital notes, and the OTs that would have come on
8 the wards, maybe physios, but the other disciplines all
9 seemed to keep their written notes as well, except
10 nursing all transferred on to this digital one. 13:57
11 213 Q. So those other professions that you mentioned, they
12 didn't enter on to the --
13 A. Oh, they did enter it, but they still kept their other
14 notes as well.
15 214 Q. Right. Okay. Was there a difficulty to doing that or 13:58
16 was there a disadvantage to that?
17 A. Some of the medical staff weren't particularly
18 comfortable with it, they preferred to have their own
19 notes, their own medical notes.
20 215 Q. Did you notice any -- I suppose you might not have seen 13:58
21 medical notes, for example, or psychology notes, but
22 would there have been -- if I can put it this way --
23 would there have been a possibility that there might
24 have been a gap in the quality of information? In
25 other words, one might have seen a less informative 13:58
26 entry on the new care plan when compared with what was
27 in that professional's notes?
28 A. I would have thought so, yeah.
29 DR. MAXWELL: Can I just ask, because I'm a bit

1 confused about what you say happened now. So there
2 were handwritten care plans, literally handwritten.
3 A. Yes.
4 DR. MAXWELL: That were personalised. And these were
5 specific nursing care plans. Obviously informed by 13:59
6 discussions with other members of the MDT, but written
7 by nurses for nurses. And then when you went digital,
8 which I presume we're talking about PARIS again?
9 A. Yes.
10 DR. MAXWELL: Are you saying that there was nowhere on 13:59
11 that to write a nursing care plan?
12 A. No, they would have said the nursing care plan was
13 there, but to me it didn't appear to be as
14 individualised or as able to be shared with the patient
15 and families to actually develop a care plan. It 13:59
16 almost was there was like a template nearly made for
17 you.
18 DR. MAXWELL: So you got a core care plan that nurses
19 just adapt.
20 A. Yes. 13:59
21 DR. MAXWELL: So there was a care plan, but because it
22 was core care plan that you adapt, there was less
23 capacity to individualise it.
24 A. Yes.
25 DR. MAXWELL: And to start -- that you would have had 13:59
26 with a blank sheet of paper.
27 A. Absolutely, yes.
28 PROFESSOR MURPHY: From what you were saying, it was
29 designed by a regional team? In other words, they

1 weren't thinking about learning disabilities. Is that
2 right?
3 A. Yes and no. They were thinking about learning
4 disability, not necessarily in a hospital setting I
5 think. It may well have worked very well in a 14:00
6 community setting where you maybe had a community nurse
7 and you would have had maybe a consultant psychiatrist
8 dealing with other disciplines with that
9 multidisciplinary care plan, but in the hospital
10 setting, and to aid the discharge process, even if it 14:00
11 was resettlement or out of the core, I think it was
12 harder to transfer.
13 DR. MAXWELL: Okay. So you've got these plans. You've
14 got the nursing one, which, because it is a core care
15 plan that you adapt is less personalised, you've got 14:00
16 psychology, you've got medical, social work, are these
17 then brought together into something called the
18 multidisciplinary plan?
19 A. The nursing care plan was first digitalised, that is
20 actually the multidisciplinary care plan. Every one of 14:00
21 them disciplines should have inputted, and if they seen
22 a patient they should have recorded it on the digital
23 multidisciplinary care plan, but they still kept their
24 medical notes too.
25 DR. MAXWELL: So are you saying nurses had a separate 14:01
26 care plan and contributed to the multidisciplinary, or
27 nursing didn't have a separate care plan.
28 A. No, they didn't. They were all onto one.
29 DR. MAXWELL: So all the professions had their own care

1 plan, except nursing.
2 A. Yeah.
3 DR. MAXWELL: And the ones that nurses put on was one
4 that was populated by all the professions. So who
5 actually put the information onto the MDT plan? 14:01
6 A. The consultant.
7 DR. MAXWELL: Was it drawn down automatically from the
8 computer?
9 A. Yeah. The consultant would have put their bit in if it
10 was at the multidisciplinary meeting, or from the 14:01
11 medical -- or nursing input would have put their bit
12 onto it, and if there was something to do with physio
13 or OT, they would have put their bit onto it as well.
14 DR. MAXWELL: So the system would extract that from
15 their records. 14:01
16 A. Very difficult to read. I think it was -- I thought it
17 was very difficult --
18 DR. MAXWELL: Okay.
19 A. When you went looking for information.
20 DR. MAXWELL: But it couldn't extract anything from a 14:02
21 nursing care plan because there wasn't one?
22 A. Mhm-mhm.
23 DR. MAXWELL: So was it extracting from other files to
24 produce something that nurses then added to?
25 A. Yes. That could have been your admission information, 14:02
26 could have come from comprehensive risk assessment,
27 they were looking about feeding, dressing, all these
28 issues they would have compiled it within that care
29 plan as the patient was being assessed.

1 DR. MAXWELL: So we've heard from other people that pre
2 this you were using a nursing model of Roper, Logan and
3 Tierney, with all the activities of daily living.
4 A. Yes.
5 DR. MAXWELL: Did this mean that you weren't recording 14:02
6 this now because there was nowhere to put it?
7 A. It was there, but not just as clear as easily found in
8 it, as you would have had in your nursing care plan, it
9 would have been the first thing you would have opened
10 up was the Roper, Logan and Tierney assessment and got 14:02
11 to it. It was just -- it just was difficult to go
12 through. I felt it was. And then there was the
13 training of staff to using it right. The worries
14 around cutting and pasting, big concerns around that
15 would have been done. To me it didn't seem as 14:03
16 personalised.
17 CHAIRPERSON: And whose job was it to pull all of this
18 together for a particular patient? We've heard that
19 each patient would have had a named nurse.
20 A. Named nurse. But they were focussing very much on the 14:03
21 nursing assessment part of it.
22 CHAIRPERSON: Yes.
23 A. Every one of the other disciplines had their own
24 responsibility to put their notes into that.
25 CHAIRPERSON: And so there was no-one responsible for 14:03
26 actually making the whole thing make sense?
27 A. No. There was many people looked at it and thought it
28 did make sense, but to me it was difficult.
29 DR. MAXWELL: So did you have a workaround? You know

1 what usually happens when you get a system that people
2 don't think is helpful, they produce a workaround that
3 isn't officially known about.
4 A. No. Well, I didn't. It was there and left to us and
5 we got staff training to get on with it. 14:04
6 DR. MAXWELL: So how did care plans get communicated?
7 If I came on duty -- if I was a bank nurse and I came
8 on duty at 7:30 in the morning and the electronic
9 system is incomprehensible, how would you make sure I
10 would know what to do? 14:04
11 A. What you seen would have been the nurse in charge maybe
12 doing an induction to that, and if it was a patient
13 they would have been picking out the care needs to that
14 patient on the digital one to share with them in it,
15 but it was very difficult for someone just to sit down 14:04
16 and open up that computer and get a brief on each
17 patient. What I found in one of my wards was really
18 useful, in Six Mile, again they typed up a patient
19 profile and kept it on the file like this.
20 DR. MAXWELL: Right. Okay. 14:04
21 A. So new staff coming, they would give the profile --
22 DR. MAXWELL: So that is a workaround. It's something
23 that's not on the system but it's what staff are
24 working to.
25 A. Oh, right. Right. Sorry, I misunderstood you. 14:04
26 DR. MAXWELL: Sorry --
27 A. Yeah, yeah. And the number of wards would have done
28 that to make it easier, rather than go right through
29 it, so they got the core needs of the patient --

1 DR. MAXWELL: So I might have this patient profile,
2 which is, you know, detailed but not part of the formal
3 record, and would I also be working from the allocation
4 sheet?
5 A. Yes. 14:05
6 DR. MAXWELL: And that would be my main information
7 about what this patient's needs were,
8 A. Mmm. And you had an induction sheet -- if it was your
9 first time on the ward, there was an induction. They
10 you would have gone through some of the fire 14:05
11 regulations, exits, the alarm system, things like that.
12 DR. MAXWELL: Yes. And were the allocations sheets
13 kept?
14 A. Yes.
15 DR. MAXWELL: So if we wanted to see them they should 14:05
16 be filed somewhere?
17 A. They should be.
18 DR. MAXWELL: Okay.
19 A. They were up until -- certainly when I retired they
20 were. 14:05
21 PROFESSOR MURPHY: And what would patients have had by
22 way of a copy of the care plan? Did they have an Easy
23 Read version given to them?
24 A. There was no Easy Read version. There was within the
25 old care plans, they were quite easy to share, and you 14:05
26 would have seen like a pen picture of their care that
27 would have been a copy of the written care plan, but
28 not with the digital one. And even for many of our
29 patients who could read, it was very hard to share that

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1 information with them. The screens were no bigger than
2 this. (Indicating).
3 CHAIRPERSON: But what about the personal profile?
4 When that was written up, would that be shared with the
5 patient? 14:06
6 A. Yeah, they could have been, yeah. In the Six Mile they
7 would have been with them.
8 216 Q. MR. McEVOY: Can I ask you now, Mr. Mills, about
9 restrictive practices. Again this is something we
10 looked at earlier. But in paragraph 91 in particular, 14:06
11 you're talking about the establishment by you of a
12 practice of having restrictive practice meetings for
13 PICU in 2016, because of the amount of restrictive
14 practices being used on the ward, and the meeting
15 consisted of the senior nurse lead, a behavioural 14:06
16 nurse, the Ward Manager, the nurse in charge of the
17 ward, a consultant, a psychologist, and yourself. You
18 met every four weeks to review the restrictive
19 practices and recommendations were made at those
20 meetings. The MDT would have been doing it on a weekly 14:07
21 basis, but you did it for your own satisfaction to
22 ensure all was being done correctly. You wanted
23 constructive discussion about rapid tranquillisation
24 restrictive practices and one-to-one observations. You
25 wanted to satisfy yourself and the hospital team. You 14:07
26 were actively looking at the area. You feel that the
27 team may have felt as though you were questioning them
28 on their decision making, and you suppose you may have
29 been, but it was a way to look at restrictive

1 practices.
2 Did those meetings have the effect of reducing the use
3 of restrictive practices?
4 A. In some cases it did. But most of it, it was looking
5 at why or how the seclusion was required in the first 14:07
6 place.
7 217 Q. By that answer, was the focus principally on seclusion?
8 A. No, I would have been looking at rapid tranquillisation
9 as well. The rapid tranquillisation would have been
10 one of the things that I would have been looking at 14:08
11 quite a bit, and that did appear to -- there was some
12 improvement in that. Seclusion always improved with
13 individual patients once you started to put a focus on
14 their care, and I was seeing the improvement. I called
15 it improvement when you seen lesser hours of seclusion. 14:08
16 And it's the same with physical intervention. But,
17 again, the more that I had these restrictive practice
18 meetings, the more I seen a need that we could have
19 been using CCTV, if it had of been up and running, and
20 a therapeutic approach to it. 14:08
21 218 Q. And we'll return to that very shortly.
22 A. But I felt it did -- I think they were quite heated,
23 many of these meetings. Because, you know, I was there
24 in a form that almost appears as if I was challenging
25 the team. 14:08
26 219 Q. Yes.
27 A. And their practices. And though initially it was quite
28 difficult, the senior nurse lead would have supported
29 me in it, but I did see improvement. I felt they were

1 useful. But, again, as things come closer to my
2 retirement, and into 2017, I just didn't feel that they
3 were taking place enough. It was coming -- there was
4 other pressures in the hospital, there was changes in
5 doctors and that, so we needed to put more of a focus 14:09
6 on to them.
7 220 Q. The frequency changed. So you instituted them in 2016
8 and you retired in 2018?
9 A. Mhm-mhm. '18.
10 221 Q. And initially they were every four weeks? 14:09
11 A. Mm-mmm.
12 222 Q. And how was the frequency of them affected then towards
13 the end of your time?
14 A. It was -- maybe poor turnout at the meeting? You might
15 have missed a member out that of team and it may have 14:09
16 went from about six weeks, we'll put it off for about
17 one month, we maybe missed a month, and then caught up
18 the following month on it.
19 223 Q. Okay. You weren't being boycotted by anybody, were
20 you? 14:09
21 A. No, no. No, I didn't feel that anyway.
22 224 Q. Yeah. Okay. You then go on to describe how patients
23 who were distressed, and this is at 92:
24
25 "...were managed by a few different methods such as 14:10
26 talking therapies used by psychologists, one-to-ones
27 with a nurse, or taken off the ward for a walk. If
28 there was stress and depression with a patient they
29 would have given time on their own. They would have

1 had an activity programme. If that stress was more
2 physical, the patient would be directed to their
3 bedroom. Patients may have been distressed with
4 entering an environment with so many other people and
5 anxious about going into a hospital setting. There 14:10
6 were three locks on the door so a patient could lock
7 their door. A nurse could lock the door and there's a
8 device where the staff could turn the key."
9
10 You go on and say: 14:10
11
12 "Where patients were physically distressed, physical
13 intervention was helpful."
14
15 You believe that: 14:10
16
17 "...restrictive practices were used the best they could
18 be with the sheer number of patients and the
19 difficulties the staff were facing."
20 14:10
21 And you went over and above, and the consultants did
22 everything they could:
23
24 "Consultants had to deal with patients from two or
25 three designated wards in Muckamore, and the community, 14:11
26 but still made time for the patients."
27
28 And you repeat the point we've touched on earlier about
29 how decisions around restraint and seclusion happened

1 at MDT meetings. You might have been called to the
2 meeting if it involved a patient on high level
3 observations or it involved changes to staffing levels.
4
5 Moving to MAPA then, you say that: 14:11
6
7 "If MAPA was used for a patient it was listed as an
8 initial form of treatment but once used it was recorded
9 and the MDT would have looked at this. To the best of
10 my knowledge restraint and seclusion were recorded, but 14:11
11 in 2017 and 2018 we discovered that it was not being
12 recorded accurately."
13
14 You told us in your evidence before the lunch break
15 about what you had picked up around the accuracy of 14:11
16 seclusion records, what was going on with MAPA? Was it
17 something similar?
18 A. I think it was the times it was going and whether they
19 could find the proper documentation in the notes, when
20 we seen the CCTV, was that MAPA was being used. There 14:12
21 might have been only a slight hold or that, but it
22 wasn't being properly recorded, and that had concerned
23 us. And people maybe not recognising the importance of
24 recording that interaction, whether they were laying
25 hands on the patient, and debriefings didn't appear to 14:12
26 be happening after it was stopped, if there was an
27 incident, and then people just got up and went on on
28 their everyday work.
29 225 Q. Was this -- can you give us some idea of the scale of

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1 this problem? Was it in every instance?
2 A. Oh, no.
3 226 Q. Was it occasional?
4 A. The only ones that I had seen it was within PICU.
5 227 Q. Right. 14:12
6 A. A few of them. And it was only followed up with the
7 safeguarding team after it when they went to look at
8 the records, they'd have came back to me and said
9 'Well, that's not recorded'.
10 228 Q. Right. 14:13
11 A. There was seclusion, or the physical intervention
12 wasn't recorded then.
13 229 Q. Did you notice patterns within the recording in terms
14 of deficiencies, and I'm not looking for names, but
15 with particular staff or groups of staff or, indeed, 14:13
16 shifts?
17 A. No, and one of the things that did surprise me, and it
18 was that it wasn't that they were short-staffed, in
19 many cases they were fully staffed when this was
20 happening. 14:13
21 230 Q. Right.
22 A. And it did surprised me. It just seemed to be poor
23 record keeping.
24 231 Q. Yes.
25 CHAIRPERSON: Sorry, does this relate to unnecessary 14:13
26 use of MAPA in your view?
27 A. No, no.
28 CHAIRPERSON: Simply the use of MAPA, but unrecorded.
29 A. Yeah, but not accurately recorded.

1 232 Q. MR. McEVOY: And what steps did you take, if you took
2 any, to rectify the problem?
3 A. Well for that short period of time that I was there, I
4 spoke directly to the Ward Manager at the time, or the
5 acting Ward Manager, and they were giving me assurances 14:13
6 that it was being recorded accurately. There was an
7 increase of monitoring anyway during the CCTV.
8 233 Q. Yeah.
9 A. So I was assured that that was being done then
10 correctly. 14:14
11 234 Q. And I suppose quite apart from other monitoring, did
12 you notice an improvement in MAPA recording?
13 A. Well, it could be matched to the CCTV when we were
14 doing the period -- yeah, that was...
15 235 Q. Okay. 14:14
16 DR. MAXWELL: Can I ask then, so you became aware,
17 because of the viewing of CCTV, that things that should
18 have been recorded weren't. Is it your perception that
19 staff weren't recognising these as MAPA interventions?
20 A. It probably would have been mine, because there were 14:14
21 fairly minor involvement, but it was still maybe
22 holding or escorting someone through, or supporting
23 them in a hold. It wasn't always people lying on the
24 ground. They could have been sitting beside them and
25 giving them assurances. Actually, what was most 14:14
26 upsetting to me was that it would appear to be good
27 practice, it just wasn't being recorded. So you hadn't
28 got the -- you weren't capturing actually good use of
29 the MAPA technique.

1 DR. MAXWELL: Yes. So would it be fair to say things
2 that used quite intense MAPA techniques, holds that
3 involved more than one person, having the patient on
4 the floor, that these were being recorded? The ones
5 that weren't being recorded were good practice, but 14:15
6 were less intense, and maybe not perceived as
7 restrictive practices by the staff?
8 A. That's exactly the way --
9 DR. MAXWELL: But the ones that were very clearly, you
10 know, two or more people, patient on the floor, they 14:15
11 had all been recorded?
12 A. That's what I -- yeah. And there would have been an
13 incident form and everything would have been done with
14 them.
15 DR. MAXWELL: Thank you. 14:15
16 CHAIRPERSON: And how much effort is required to record
17 MAPA? If you've taken a patient by the elbow, for
18 instance, and you're ushering them somewhere, how much
19 effort is it then to record that?
20 A. It's not that much effort, you know. It's no different 14:16
21 than telling the nurse in charge that the patient had
22 ate their full meal, or if they had a fall. It's not
23 that difficult.
24 CHAIRPERSON: It should be automatic?
25 A. Yeah. 14:16
26 DR. MAXWELL: But of course at this stage the health
27 care assistants, who might be the people taking a
28 patient by the elbow to take them into the bathroom,
29 couldn't do the direct entry.

1 A. No. But they could have still went and spoke to them.
2 DR. MAXWELL: They could still tell them. But, yeah,
3 it's another step in the process, having to find a
4 registered nurse and tell them, and then them entering
5 it. 14:16
6 A. Yeah.
7 236 Q. MR. McEVOY: 97 and 98, Mr. Mills, you talk about some
8 encounters or experiences of patient seclusion that
9 you've specifically recalled. One is in relation to
10 patient P60 there at 97. You recall how his times of 14:16
11 seclusion ran into two, three, or four hours, and he
12 was very distressed and staff could not administer any
13 more tranquillisation to him.
14
15 You go on at paragraph 98 to talk about him again. He 14:17
16 was transferred out of the PICU to Six Mile ready for
17 discharge. He was transferred because of the sheer
18 demands for beds in the PICU, and he was compatible
19 with patients in Six Mile. He became very ill within
20 six months of his transfer and required and requested 14:17
21 seclusion again, but the only way to get him back into
22 PICU was a bed swap. He was then given seclusion in
23 Six Mile, this was recorded, and a seclusion room.
24 Here it was not purpose built room. He didn't want to
25 go to his room but wanted seclusion. 14:17
26
27 "The room was a white room with a sponge type bed which
28 looked into small garden area. The seclusion room
29 setup within Six Mile Ward was unusual but specific to

1 the patient's needs."
2
3 Patient P60 seems to stick with you, even at this
4 remove, in your recollection. Is there a reason why
5 his experience has stayed with you? 14:18
6 A. Just such -- well, one, he was a patient that was
7 identified very early on that would have benefitted
8 from a medium secure unit.
9 237 Q. Yes.
10 A. And he had come to Muckamore quite later on in life. 14:18
11 I'm sure he was -- had assessed as a learning
12 disability.
13 238 Q. Just speak up a wee bit.
14 A. Sorry. I think he had been in a number, or one at
15 least Mental Health Hospital, and had been treated from 14:18
16 when he was quite young in it. But he had this circle,
17 and it was so obvious.
18 239 Q. Yes.
19 A. He'd become well, things was great, he was really well
20 when he first -- well, he wasn't 100% right when we 14:18
21 moved to Six Mile, but he was getting there, and the
22 supported staff within Six Mile had him out, he was
23 visiting various farms, pony trekking, he had a big
24 interest in horticulture and farming, and he had a
25 great wide range of activities and was very good. But 14:19
26 staff could see the triggers. He was starting to come
27 back around again to becoming unsettled, and anxious,
28 and he always requested seclusion. I was uncomfortable
29 with it whilst he was in ICU. And even though he

1 wanted his door locked and closed, I insisted that they
2 record it as seclusion, because he couldn't get back
3 out of the room again, and it was the only way that we
4 could monitor it properly. Because it wasn't that he
5 wanted to lie down on a bed in the room, he wanted the 14:19
6 door locked. And the staff themselves felt that he was
7 in the wrong unit. He wasn't from a forensic
8 background. Intellectually he fitted in very well with
9 the rest of the group, but his demand for that
10 seclusion was very high when he become unwell. But he 14:19
11 was a lovely patient.
12 240 Q. Yeah.
13 A. And he had a great personality as well. And his family
14 were very heavily involved with him. And we tried
15 stuff, particularly in ICU, that I think we were 14:20
16 verging on what medium secure would require. We put in
17 a high level of -- the consultant psychiatrist spent a
18 lot of time with him, psychology spent a lot of time,
19 behavioural team did, but it wasn't consistent, and I
20 felt that's why, because we hadn't the resources, 14:20
21 that's why we've got the vicious circle in it. But he
22 was always there, and both from -- he was aggressive at
23 times, yeah, but staff had a very good rapport with
24 him.
25 241 Q. And was his experience -- from your perspective as a 14:20
26 manager and a senior manager within the hospital, can
27 you tell us whether his experience was typical or
28 untypical of a patient during that period within the
29 hospital?

1 A. Untypical. I think he was unique.
2 242 Q. Right.
3 A. And I think in many ways we failed -- I think the
4 health service in Northern Ireland failed him. I don't
5 believe -- and I feel strongly about him in particular, 14:21
6 because I think if we had of been strong enough and had
7 a medium secure unit in Northern Ireland, things would
8 have been a lot different for that patient. I think he
9 should have had the opportunity of receiving medium
10 secure treatment 14:21
11 CHAIRPERSON: Could you just pause for a second. My
12 transcript has stopped.
13 PROFESSOR MURPHY: Yes, mine has stopped as well.
14 CHAIRPERSON: I've tried reconnecting, with no success.
15 Can I just look around the room. Is anybody else 14:21
16 having problems or not? Problems. Yeah. Obviously, I
17 don't want to lose any time, but it is important that
18 we can mark up our transcripts as we go. I think we've
19 got to do it, I'm afraid, because we've got to make
20 sure that it's coming through. I'm really sorry. We
21 might just sit here for a second. I think we've all
22 stopped at the same point, which is about five minutes
23 ago. There's a wi-fi issue.
24
25 [Short pause in proceedings to resolve wi-fi issues] 14:22
26
27 CHAIRPERSON: Right. Okay. Sorry to interrupt.
28 A. No problem. That's okay.
29 MR. McEVOY: Chair, hopefully you're able to tell me

1 where I left off.
2 CHAIRPERSON: Your last question was:
3
4 "Was his experience -- from your perspective as a
5 manager and a senior manager within the hospital, an
6 you tell us whether his experience was typical or
7 untypical of a patient?"
8
9 And--
10 MR. McEVOY: We have the answer. We have the answer. 14:23
11 That's great.
12 243 Q. Can we then just go back to look again at the theme of
13 CCTV, which you take up at paragraph 101 on page 31,
14 and you're returning to a point that you made earlier
15 on in your statement which was that CCTV within the 14:23
16 hospital was your idea because of a number of
17 allegations that had been made since you took up post
18 in 1998 about patient assault, allegations against
19 staff, and staff injuries. The PPU, that's within the
20 police: 14:23
21
22 "...would have asked on numerous occasions for the
23 implementation of CCTV on the wards as it would be
24 easier for them to investigate in terms of
25 safeguarding." 14:23
26
27 You talk about your contacts with PPU and you also
28 described then how, from a therapeutic perspective, you
29 thought CCTV would be useful. For example, seeing how

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1 a patient acted from admission onwards, or if there was
2 a physical restraint incident, what staff interaction
3 was like at the time, and afterwards for MDT review:
4
5 "There were objections from patients and relatives to 14:24
6 its implementation. The Independent Patient Focus
7 Group thought that there were privacy issues and
8 consultants thought that it might unsettle patients,
9 but the police would still be mentioning that CCTV
10 would be useful." 14:24
11
12 You say:
13
14 "There were issues surrounding safeguarding in the
15 hospital, and H507, after her appointment in 2012..." 14:24
16
17 - and as we touched on earlier:
18
19 "...appointed H201 to be the Safeguarding Officer."
20 14:24
21 You understand the police asked H201 the same sort of
22 questions about why there was no CCTV to capture issues
23 such as patient-on-patient incidents, staff-on-patient
24 incidents, or patient-on-staff incidents. You can't
25 remember staff names, there weren't prosecution coming 14:25
26 from any investigations.
27
28 In late '12 or '13 after a hospital management meeting,
29 H507 said to you that "you've got your CCTV". You

1 describe how you believed that there was end of year
2 money available and it was decided to be used for CCTV.
3
4 Do you know whether, just on that point about the
5 availability of funding for it, do you know whether the 14:25
6 proposal was put forward to the Belfast Trust Board for
7 CCTV?
8 A. I don't think at that stage -- when I was first told
9 about it I don't think it was, no.
10 244 Q. No. So when H507 said, "you've got it", where did you 14:25
11 understand her authority to say that to you came from?
12 A. From, again, that management team. From the
13 co-director. I believed there was end of year money
14 and that could have been captured in the CCTV. I mean
15 they had no idea of costs. There was no business plan 14:26
16 put in place for it.
17 245 Q. Yes.
18 A. There was no consultation really, well full scale
19 consultation at that period, other than we were
20 designing it, and it initially was to look at one ward, 14:26
21 to have it done. We had the business manager up with
22 the business plan for it and it went forward. It was
23 made very, very clear to me at early stages that this
24 was going to be for safeguarding and safeguarding only.
25 246 Q. Yes. And you pick that up indeed at the end of 14:26
26 paragraph 101, over on page 32. You say that H507 told
27 you that CCTV was not to be used for therapeutic
28 purposes, meaning that you, as well as everyone else in
29 management, could not observe staff activity. You were

1 then reluctant about its implementation because that
2 was the whole point?
3 A. I wasn't -- I was keen to get it in because, yes,
4 safeguarding, and particularly that would be, it would
5 have been brilliant to have it, and I felt that was -- 14:27
6 at least it would help from one angle. And I always
7 had this thinking and feeling 'well, we'll get it in
8 that and we can push on further down the line and say,
9 look, there's a therapeutic value to this and this can
10 be proven, but let's get it up and get it running, and 14:27
11 run it under the safeguarding', but it was the most
12 frustrating project I was ever involved in.
13 247 Q. And you say at 102, you describe how in mid-2013
14 contractors came in to install it, and it didn't,
15 despite your wishes, capture or record sound? 14:27
16 A. Mhm-mhm.
17 248 Q. And there was discussion about a policy and many drafts
18 were rejected?
19 A. Yeah, because the only policies that I would have come
20 across of similar areas, and I had done a bit of a 14:27
21 search from England, and whether it was through the
22 Internet or what, there was no policies in Northern
23 Ireland that I could find for the use of CCTV in any
24 other units.
25 249 Q. Yes. 14:28
26 A. That I knew of. And, so, we had things like being able
27 to observe if there was litigation, there were issues
28 that it was rejected for that. I still tried from a
29 therapeutic perspective that it could be used as a form

1 of a review of an incident by the multidisciplinary
2 team. It was rejected. We then had to go back to look
3 at human rights issues, privacy and dignity. It just
4 seemed -- and then when a draft policy went, it seemed
5 to be ages before we got anything back again. The 14:28
6 business manager was leading it through. And the final
7 one was finally agreed in 2016/17.
8 250 Q. What you say at paragraph 104 actually, 104, at the
9 bottom of page 32, on that point, was that you were
10 frustrated about the policy surrounding CCTV. There 14:29
11 was no Trust-wide policy about it?
12 A. Mhm-mhm.
13 251 Q. Bluestone, for example, didn't have a policy at the
14 time they could have shared with you. Your policy was
15 rejected by the hospital management team, consisting of 14:29
16 Mr. Veitch, H50, that's the doctor, H287 ,
17 H507, and H201 the Safeguarding Officer. And then you
18 say just to pick up specifically:
19
20 "It was agreed in June 2017 that the CCTV would go live 14:29
21 on the 5th August 2017."
22
23 And you didn't meet with issues from staff with regards
24 to its implementation?
25 A. Actually, I had no issues from any member of staff 14:29
26 about the CCTV.
27 252 Q. Yeah.
28 A. They were always very keen to have it up and running.
29 253 Q. So we have, I suppose just to summarise what you have

1 said there, we have a period from -- well you being
2 told in late '12 or '13, you think, that you've got
3 your CCTV by H507. The contractors then come in and
4 install it in mid-13 and then it's four years hence in
5 mid-17 that there's finally a policy in place. So can 14:30
6 you enlighten the Inquiry from your perspective on the
7 reason for the delay in getting a policy in place?
8 A. There's nothing that I can -- other than purely the
9 delays in the policy procedures within the Belfast
10 Trust, it seemed to take for ages coming through. The 14:30
11 staff were convinced that it was running. A couple of
12 ward managers approached me saying that it was running
13 and they asked the business manager and he gave them
14 assurances that it wasn't running.
15 14:30
16 The policies, I have no idea, other than changing of
17 names. I was initially on the first policy as one of
18 the people that would review it if there was a
19 safeguarding incident with another -- you wouldn't have
20 been going on your own anyway to review it. I was 14:31
21 taken off it, and the only people that were --
22 254 Q. So what was it you were taken off?
23 A. I was taken off one of the drafts.
24 255 Q. Of the policy?
25 A. The policy. Yeah. 14:31
26 256 Q. Yeah?
27 A. And the only viewers was the people on the hospital
28 management team and the Safeguarding Officer. I know
29 it can be slow getting policies through, but I never

1 thought it was going to be that level of time.
2 DR. MAXWELL: So you said earlier that there were
3 concerns about human rights and data protection. So
4 the policy was presumably going further than John
5 Veitch and the rest of the people? 14:31
6 A. Oh, it was right throughout the Trust.
7 DR. MAXWELL: I think that's reflected on the policy,
8 when you see the final policy.
9 A. Yeah.
10 DR. MAXWELL: So it was going to lots of different 14:31
11 committees, then coming back to you, and then it had to
12 go through this same round of committees again.
13 A. Uh-huh. It just seemed to be every obstacle I could
14 come across with it. And even right up to the very
15 end, I don't know why it didn't go live on the 5th 14:32
16 August, but it was to go live. I was on leave at that
17 period, when I came back and it still wasn't -- and
18 then it did come on in, and I think that's why the
19 relative was given -- there was a meeting with the
20 relative of the first one that we identified as there 14:32
21 was an allegation of abuse before CCTV was looked at,
22 and they said 'Are you sure that this is not running?',
23 and I kept saying to the business manager, 'Look, this
24 was to be live on the 5th. Is it policies again was
25 stopping it from going through and was it working 14:32
26 live?', and that's when they went away and checked it
27 and it was running.
28
29 But I understand some, some policies are quite

1 difficult to get through, but I never in my wildest
2 dreams thought it would have took that length of time.
3
4 But I do still, and I still feel strongly that there is
5 a therapeutic element to CCTV in assessment units, or 14:32
6 any unit for people with a learning disability that has
7 restrictive practice in it. Just to have -- it's not
8 just about safeguarding, it's about learning from it,
9 and you couldn't possibly have anything better than
10 looking at it and listening to it, if you could hear it 14:33
11 too, for every incident.
12 DR. MAXWELL: You made that point about not having
13 sound. Was there not an option to commission something
14 with sound?
15 A. That wasn't put to me. 14:33
16 CHAIRPERSON: Could I just mention so that everybody
17 knows, the transcript is going much slower today, it's
18 pushing at a much slower rate, but it's fine, we're
19 going to continue.
20 257 Q. MR. McEVOY: Okay. At 107, you return to the theme of 14:33
21 resettlement. You tell us that you did not have any
22 training for the discharge in resettlement process.
23 The resettlement package was the responsibility of the
24 patient's own community team. None of your staff had
25 any training in relation to resettlement. Until 2012, 14:33
26 John McCart, and Petra Core, a lead psychologist, had
27 set up monthly meeting specifically for Belfast Trust
28 patients within the hospital regarding their admission,
29 treatment and discharge planning.

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1 A. No, that was -- that actually finished around 2012.
2 Before that it would have been from about 2008 that
3 should be. John McCart and Petra Core up until 2012
4 had this meeting, and it was Belfast Trust
5 specifically. I found it really useful, and my ward 14:34
6 managers felt it useful.
7 258 Q. Yes.
8 A. It gave me a better insight into the difficulties that
9 the community teams were having to maintain someone in
10 the community setting. 14:34
11 259 Q. So the Inquiry has hard from Mr. McCart, and we know,
12 indeed, and you've recorded that he retired and,
13 indeed, we've also heard from Dr. Core who left the
14 Trust and began working at the Northern Trust, and she
15 set up a similar meeting there, but did anybody take 14:34
16 over those roles?
17 A. People took over them, but they didn't carry on with
18 that format of meeting, no.
19 260 Q. Okay. Did they carry on with any format of meeting?
20 A. No, not like that, no. Not involving the hospital. 14:35
21 They may have carried it on within their own teams, but
22 they didn't invite anyone from the hospital to their
23 meetings.
24 261 Q. Yeah. Okay.
25 A. I think it's the value that the staff themselves felt. 14:35
26 Because when we were isolated within Muckamore away
27 from the Belfast Trust, we were thinking, well, look,
28 you know, what's happening here, you know? Are these
29 people just being admitted for no reason and what's the

1 discharge plans? But they were really robust meetings.
2 They held everyone to account, and they looked at, you
3 know, the breakdown until the admission to the
4 hospital, and what had been done, and then what could
5 be done to prevent their admission, even before they 14:35
6 went out. I'm not saying it was ideal, it helped with
7 every admission, but certainly I found it very useful.
8 262 Q. Can I ask you then about the question of patient
9 finances, please? And you deal with that on page 35 at
10 paragraph 113. Thank you. In acute wards, you say: 14:36
11
12 "...patients did not have many funds in their accounts,
13 but on discharge wards the patients had built up larger
14 amounts. There were questions that staff were being
15 funded by patient finances. This is untrue. Patients 14:36
16 received therapeutic earnings from the Belfast Trust.
17 Through this, patients would be given £5, £10 or £15,
18 for example, and staff could get a coffee for a patient
19 themselves. There was a point in time that therapeutic
20 earnings were stopped for new admissions, but this was 14:36
21 challenged and then this money was reimbursed and the
22 system re-started."
23
24 Now, the Inquiry has heard some evidence that patient
25 finances were effectively pooled across patients. Do 14:36
26 you think that happened? Do you think that was the
27 case?
28 A. Not to my knowledge. Pooled. They had therapeutic
29 earnings. The therapeutic earnings was stopped for a

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1 short time in Muckamore, but that was a Belfast Trust
2 -- they stopped giving people an allowance for
3 attending day centres.
4 263 Q. Yeah.
5 A. But we argued that and it -- 14:37
6 264 Q. It came back.
7 A. So if someone was maybe going on an escort out as part
8 of their discharge plan to maybe go to a coffee shop in
9 Antrim, or even over to a community centre and that,
10 rather than staff sitting there with it, that could 14:37
11 have been used to support them. But there was also
12 petty cash on a ward to pay for staff as well for some
13 of these outings.
14 265 Q. Yes.
15 A. But not pooling, pooling money. 14:37
16 266 Q. Okay. All right.
17 A. Maybe if they were buying a Chinese on a ward or
18 something like that, or meals -- they wouldn't pool it
19 together, it wouldn't have been round off figure, they
20 had the list of what was ordered. 14:37
21 267 Q. Yes.
22 A. And that's what it was done. But not to my knowledge.
23 268 Q. You would have expected to have seen something like
24 that properly accounted for?
25 A. Yeah. Same with -- some -- though I wasn't involved in 14:38
26 resettlement, but some of our patients who were moving
27 out got allowances to purchase furniture and items, and
28 some of them bought them maybe away a year in advance
29 of them going out, which I was uncomfortable with

1 because it was personal items going into rooms and
2 that, and that was different.
3 269 Q. Let me ask you then on page 36, paragraph 116, about
4 staff numbers and staff welfare generally. Now we have
5 talked about staff numbers, but in terms of the 14:38
6 practical impact of shortages and so on, on staff, you
7 say that if a staff member had to go off duty or had to
8 go to Occupational Health support, you'd have referred
9 them to it.
10 14:38
11 "The big issue was that it was so normal for assaults
12 from patients on staff that they did not take the time
13 out to recover, and this may have been because of
14 staffing levels, but between 2014 and '16 it was the
15 norm for staff to be assaulted daily." 14:39
16
17 You were not playing it down as a manager:
18
19 "It was difficult for staff, but it was amazing how
20 resilient they were. There were some traumatic 14:39
21 incidents and I would have went to the ward to try and
22 support staff, but there was not staff to even relieve
23 the assaulted staff member."
24
25 Looking back again on it, is there anything else -- I 14:39
26 know this maybe necessitates hindsight, but is there
27 anything else you could have done about staff numbers
28 and their welfare, given what you're telling us about
29 assaults, their frequency, and severity?

1 A. I suppose an analysis on that there, looking at it now,
2 we should have been looking at staffing levels to be
3 enhanced on the basis of them incidents, that we should
4 have maybe had our numbers. If there was a shift
5 requirement for seven staff a shift, we should have 14:39
6 been increasing the staff numbers to allow for these
7 incidents. Not to make them the norm, but to have the
8 support or a pool of staff. And in ways we did try to
9 do that, but that was putting staff in a relief that
10 didn't know the ward, and it was just after an 14:40
11 incident, and that was difficult too, putting people
12 just new into an unit like that. There's lots of stuff
13 in hindsight that I could have done more --
14 DR. MAXWELL: Can I ask about Datix reporting, because
15 in other evidence we've seen that actually there was a 14:40
16 dramatic increase of reported assaults by patients on
17 staff from 2012 onwards. So, you had a governance
18 arrangement and you had somebody who worked on
19 collecting the data. Was it ever discussed, this has
20 gone up -- 14:40
21 A. It was discussed.
22 DR. MAXWELL: -- significantly?
23 A. I would have arranged it. But it may have went up a
24 bit in '12, but there was a lot of work being done in
25 2010 and '11 to get people to report these. 14:41
26 DR. MAXWELL: Yeah.
27 A. And it was maybe I would have said in 2011 that it was
28 starting to increase, but you seen the gradual increase
29 of people reporting it. They were so taking it as the

1 norm in it. But the analysis of it, it went -- I
2 assumed, when I was going to the hospital management
3 team, which was my link to the bigger Trust, all this
4 information was going up the chain as well in it. And
5 I discussed it with Occupational Health on many 14:41
6 occasions to see is there anything else that we could
7 do? But I don't believe now that it went much further
8 out of the hospital.
9 DR. MAXWELL: I mean did it get put on the hospital
10 Risk Register? 14:41
11 A. No. It went on -- the staff shortages linked maybe to
12 some of these incidents.
13 DR. MAXWELL: But not staff injuries.
14 A. No.
15 DR. MAXWELL: And why was that not -- 14:41
16 A. It was on the Risk Register, but it didn't go to red
17 alert, the higher level in it.
18 DR. MAXWELL: Okay.
19 A. Which I think now - well thinking now going on red
20 alert, what did it mean? It certainly didn't make much 14:42
21 of a difference to me and my staff when we went on to
22 red alert, and how far up the chain in the Belfast
23 Trust did that red alert go to?
24 DR. MAXWELL: Okay.
25 270 Q. MR. McEVOY: Indeed, at paragraph 117 you have 14:42
26 described a number of particularly serious incidents of
27 patient-on-staff violence. One where a staff member
28 was thrown through a glass patio door and assaulted
29 severely, and there was a transfer of that patient out

1 of the hospital to mental health services.
2
3 Again, you discuss an incident involving P60 and an
4 assault in relation to a staff member and it's effect
5 on that staff member. You say: 14:43
6
7 "A lot of staff would have had PTSD but they took what
8 happened as the norm..."
9
10 - as normal. 14:43
11 A. Yes.
12 271 Q.
13 "The types of incidents were also traumatizing for
14 other patients to witness."
15 14:43
16 And, again, you make the point that if CCTV had been up
17 and running and there had been the ability to view
18 footage for therapeutic purposes, you would have been
19 able to analyse incidents and make the hospital safer
20 for patients and staff. 14:43
21
22 You may have touched on the point in your response to
23 Dr. Maxwell, but do you think serious assaults of staff
24 by patients were appropriately escalated, and do you
25 know whether the Trust Board were properly informed? 14:43
26 A. I don't know if they were properly informed. I assumed
27 that they were, but I didn't, because I didn't see many
28 of the Trust Board on site to even question them.
29 272 Q. Yes.

1 A. But everyone else who visited the hospital were aware
2 of it, and RQIA were very much aware of it.
3 273 Q. Yes.
4 DR. MAXWELL: The RQIA were aware that staff were being
5 assaulted? 14:44
6 A. Yeah. The staff would have told them when they were
7 visiting, and they would have had access to the data
8 that we would have been giving to the governance
9 people, they would have access to that. They would
10 have asked for them incidents, the incident forms, 14:44
11 before when they came onto the wards.
12 DR. MAXWELL: And do you recall them, when they were
13 giving their feedback after visits, discussing this
14 with you?
15 A. Yeah. 14:44
16 DR. MAXWELL: They did?
17 A. Mhm-mhm. And staff shortages too. We would have
18 talked about staff shortages as well.
19 MR. McEVOY: I was just going to pick up on staff
20 levels with you in fact at paragraph 120, and you say 14:44
21 that:
22
23 "Everything went through the hospital management team.
24 They were the avenue for raising issues such as staff
25 levelling, recruitment, and incidents about seclusion. 14:44
26 Their offices were outside the hospital. There was a
27 line management process..."
28
29 - and that's what you followed. You had no contact

1 with staff Associate Directors apart from on visits?
2 A. Mhm-mhm.
3 274 Q. Was there any avenue to pick up the phone to contact
4 them if an urgent issue arose, or was the assumption,
5 was it a sort of 'don't call us, we'll call you' type 14:45
6 of relationship?
7 A. Yeah, that's it. I would have went straight to my line
8 manager. If you're talking about outside of the
9 hospital, it would have been the governance lead or the
10 co-director. You would have had the Medical Director 14:45
11 who would have been linking into the Medical
12 Directorate and that.
13 275 Q. Yes.
14 A. So that was my avenue. So that's who I went. And then
15 there was another new tier of management came in, 14:45
16 Associate Directors, there was H507 become an Associate
17 Director of Nursing, and that was more moving into that
18 area. But Directors started to come in on the
19 leadership walkabouts. But they were -- they notified
20 the ward that they were coming, in it, and to me... 14:46
21 276 Q. Yes. You've given the example there of Mr. Devlin,
22 Shane Devlin, being one Director you received follow-up
23 from who went on to an executive role. He was the only
24 one to follow up on staffing levels or anything he saw
25 on his walkabout. Would he have notified you, notified 14:46
26 the hospital that he was coming?
27 A. Oh, yeah, they knew they were coming. It was the same
28 format. But I'm talking about what he identified maybe
29 speaking to staff, what he had identified as

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1 recommendations or issues that we were working on, his
2 office would have contacted me for an update, and what
3 we were doing about recruitment and issues like that.
4 The other ones I had never any contact from.
5 277 Q. At the end of the paragraph, the same paragraph 120, 14:46
6 you say that you were:
7
8 "...shocked when the allegations of abuse came out in
9 September 2017, and the directors were shocked about
10 how poor staffing levels were." 14:46
11
12 But you make the point that:
13
14 "Staffing levels and seclusion levels were consistent
15 for five years up to this point, yet these people were 14:47
16 shocked when they should have known about this and had
17 been in the loop with the information."
18
19 Dr. Maxwell asked you about staffing levels and whether
20 those were on the Risk Register a few moments ago. 14:47
21 What about seclusion, do you know whether it was on the
22 Hospital Risk Register?
23 A. I don't. I couldn't answer that. I'm not sure.
24 278 Q. Okay. Staffing concerns and seclusion rates, you're
25 telling us here, were consistent for the five years 14:47
26 prior to August '17. That was an increase from the
27 same period in 2012 then, is that what we're to take
28 from that?
29 A. Yeah. They were constantly going up, yeah.

1 279 Q. Looking across to paragraph 125, you talk about the
2 period towards the end of your career within the Trust.
3 You say that, there was:
4
5 "In the last few years there was training within the 14:48
6 Trust for all of us in managing change, but in
7 hindsight the training was tailored towards an acute
8 hospital setting or a department."
9
10 You don't think the Trust, or you for that matter, knew 14:48
11 the magnitude of change that was happening within the
12 hospital. For example, changes around resettlement,
13 admissions, or when children moved from children
14 learning disability services to adult services. You
15 didn't realise the complexity. You had to deal with 14:48
16 the change in culture in the hospital as people were
17 not returning to work and you had temporary staff:
18
19 "I felt sorry for the staff that worked in resettlement
20 ward as when it closed they had to move ward and there 14:48
21 was very little transitional training to know the new
22 staff and ward managers. Sometimes those closures
23 could happen overnight which caused problems for staff
24 and patients."
25 14:48
26 You feel the process could have been handled better by
27 yourself and others.
28
29 What kind of notice did you have of ward closures, and

1 I suppose we can deal with that point first, what kind
2 of notice did you have?
3 A. Well I remember the changes in Erne, it was probably a
4 day's notice. That's what the staff got. They were
5 told when they were moving from them they would become 14:49
6 permanent. They were being made temporary to
7 permanent, and that would have been -- that was a day,
8 that was big effect on staff. A closure of a ward,
9 you're talking maybe about a week.
10 280 Q. Was that typical? 14:49
11 A. Pardon?
12 281 Q. Was that typical?
13 A. Yeah. They'll say -- people will argue 'Well, they all
14 knew the ward was closing', yeah, we did know the ward
15 was for a long time, but we didn't know that it was 14:49
16 going to close and then transfer to another ward.
17 282 Q. Yes. So in other words it was what was going to happen
18 afterwards?
19 A. Yeah. And even with the closure of -- it was the
20 transferring of Killead Ward to Cranfield Ward, which 14:49
21 was an idea of mine said in an informal manner at a
22 meeting, there was no business plan, or plan put on
23 paper for it, but we had large numbers of admissions
24 into our female wards, they were always bed blocking in
25 it and trying moving patients out to other areas of the 14:50
26 hospital for a night, there seemed to be more female
27 patients required, and we had more beds in Killead, and
28 I spoke to the two ward managers and we discussed it,
29 it would have been better to actually swap it over.

1 But it was -- again, when I was on leave there was a
2 crisis with beds and they decided to put that idea in
3 place. Now I had spoke to it more and planned it more
4 with one Ward Manager, but I hadn't it with another
5 one. So one ward moved swiftly across with very little 14:50
6 problems. The other ward, Cranfield Womens' moving
7 into Killead was chaos, because, you know, there was
8 staff coming back from leave, and this was in July or
9 August time, and they were walking into a ward and
10 their ward had moved. They hadn't had time to speak to 14:50
11 them. They hadn't had time to speak to the relatives.
12 And that -- yes, there was an improvement in the
13 environment long-term, but we hadn't that time to plan
14 it. But, again, it was just this panic because there
15 was a crisis and then we moved. If that was happening 14:51
16 in the core hospital with reasonable numbers, what it
17 must have been like in some of them other wards when we
18 were going from one resettlement ward to another, it
19 must have been very frustrating for both staff,
20 patients, and relatives. 14:51
21 283 Q. Well in light of all of that, is there anything,
22 looking back on it, you think you might have been able
23 to do, and I mean the corporate you, to handle those
24 things better, those closures better?
25 A. I think you need to sit down with staff initially first 14:51
26 to see if there is a plan in place for moving and how
27 they can support the patients. And that should be
28 known throughout the whole of the hospital, whether
29 it's the closing or moving of a patient from one ward

1 to the other as part of the resettlement. They needed,
2 staff needed to be updated and a clear plan of where
3 we're moving to next. If it's going to be Finglass
4 Ward closes and moves to Rathmullan, or Rathmullan
5 closes and goes to Greenan, staff need to know that. 14:52
6 Then we need to be preparing our patients for that. No
7 different than being discharged out of the hospital.
8 And relatives being involved in that too.
9 284 Q. Yes.
10 A. But as I say, yes, we have strong relative 14:52
11 representation now, but a lot of our patients didn't
12 have relatives to support them, so we needed the TILII
13 and advocates there to help with them. But, yeah, I
14 think a lot of support. And I'm not sure about the
15 idea of keeping staff, all the staff that were in 14:52
16 resettlement wards there to the very end. We could
17 have been moving some of the temporary staff over as we
18 transitioned on through to the closure of all the
19 wards.
20 CHAIRPERSON: Can I just ask, given the preparation 14:52
21 that has to be done for resettlement, even when you're
22 moving a patient from one ward to another, does that
23 take some significant preparation for some of these
24 patients?
25 A. I believe so, yeah. I think we have to look -- we 14:52
26 didn't look at it right, or I didn't -- I had nothing
27 to do with the resettlement, but I would have voiced my
28 opinion on it, and I think I said very early today
29 that, you know, we were all being driven by a budget.

1 Our hotel services staff, our estates, nursing, physios
2 whatever, and they were reducing their numbers. And,
3 you know, we talked about a domestic may not have went
4 with them patients, but could have been vital to go
5 with them. That one domestic or a friendly face that 14:53
6 they seen out on the floor with them. Equally so, we
7 could have picked a healthcare support worker
8 necessarily, they might have had two named nurses,
9 there needed to be more thought gone into that. If I
10 was doing it again, I would do take that approach to 14:53
11 it.
12 CHAIRPERSON: From what you've described, it sounds as
13 though, certainly from your perspective, there was a
14 significant gap between management decisions being made
15 and you being alerted to what those decisions were and 14:53
16 being able to make any preparation for it, is that fair
17 or unfair?
18 A. Yeah. Not me personally, because I wasn't with the
19 resettlement wards, but it had a knock-on effect in the
20 core hospital with other staff, because just it was 14:54
21 closing, and people were moving, and the temporary
22 staff that I had they were 'well, am I going to be
23 moved now?', and I couldn't tell them whether they were
24 going to be moved. I assumed that they were, but they
25 didn't. It went on for years. They stayed with me. 14:54
26 And it was unsettling. Do I renew a temporary staff's
27 contract for another year or six months? I didn't want
28 to be giving people out monthly contracts. Planning
29 your bank staff, planning day services. But, as I say,

1 it was '15, 2015 or so, I had gave up day care
2 services. But that -- we cut back far too soon on it.
3 285 Q. MR. McEVOY: Mr. Mills, at paragraph 133 then on page
4 41, here you talk about the Serious Adverse Incidents
5 Report coming out at the end of August '18, and 14:55
6 suspension of staff from PICU. You describe feeling
7 aggrieved. You had been involved in the suspension of
8 a large number of staff from that ward. You were
9 summoned to a meeting with H507 and 290, and a senior
10 nurse within the corporate nursing team. The meeting 14:55
11 took place in the visitor's room in PICU and you were
12 told that the Director of Nursing in the Trust and the
13 Chief Nursing Officer wanted assurances from you that
14 PICU would be safe over that weekend. They wanted you
15 to move staff from other wards in the hospital to PICU. 14:55
16 You tried to explain that moving staff from other wards
17 into PICU would make the rest of the hospital unsafe
18 because additional senior nursing resource had already
19 been allocated to PICU, leaving other wards lacking in
20 senior nurses. Nevertheless, you had to give 14:55
21 assurances that PICU would be fully staffed for this
22 period of time, and:
23
24 "I reluctantly agreed to move senior staff from other
25 wards into the ICU." 14:56
26
27 This was a day or so before you went on leave for a
28 week. You then say:
29

1 "I could not give assurances to my ward managers that I
2 could get replacements for the staff who were being
3 moved. They were instructed to look at using agency
4 staff, bank nursing staff, or attempt to get current
5 staff to do overtime. I could not give an explanation 14:56
6 to the staff about why this was being done. I believe
7 the focus was on the PICU ward because this was the
8 ward where the first allegations of abuse emerged with
9 the CCTV. We had not reviewed CCTV on the wards and
10 there was a state of hysteria within the hospital with 14:56
11 what was going on and how it was being handled at a
12 senior level."
13
14 Now, this hysteria that you describe was happening at
15 management or staff level? 14:56
16 A. Oh, absolutely at management, senior director level, I
17 felt that the hysteria was coming.
18 DR. MAXWELL: What do you mean by senior director?
19 A. Well, there was directors now were very present on
20 site. 14:57
21 DR. MAXWELL: Are you talking about Trust Board
22 Directors?
23 A. Yeah. They were seen on the site, the Director of
24 Nursing was down, Director of Social and Primary Care,
25 and various -- and other senior managers from within 14:57
26 the Trust were on the site, and things were just
27 changing by the day. That sense of panic went down
28 right through us right down onto to the floor where
29 people were working. There was people being suspended

1 on a regular basis. Things were coming in like
2 supervision, I had never -- it was under safeguarding
3 -- this had tapered into a thing that I had never come
4 across before under safeguarding, or if I had concerns
5 they were either suspended, nothing, I didn't know when 14:57
6 the supervision was going to end, and I was actually
7 instructing it as part of a safeguarding thing.
8 People, some people were being put under enhanced
9 supervision, some people were being suspended.
10 14:58
11 But going back to what I was first saying, that to try
12 to make one area -- to give assurances to the Chief
13 Executive Nurse and to the Director of Nursing, we had
14 put in what we could. There was a Senior Nurse
15 Manager, an 8A, put in to manage the ward during that 14:58
16 time. There was other senior staff put into the ward.
17 But there was an insistence that I had to bring more
18 people in to give assurances. And what I done, I
19 believe that it put the rest of the hospital at risk
20 that week, and we did it, we got through it, but there 14:58
21 was incidents that happened on that week when I was off
22 that certainly -- before I left I was -- I had decided
23 that I would retire in October, because I had no
24 control over -- I wasn't making any management
25 decisions in the hospital. It was being led from other 14:58
26 areas.
27 DR. MAXWELL: So you're saying you moved staff to PICU
28 as instructed?
29 A. Mhm-mhm.

1 DR. MAXWELL: And you thought that put the other wards
2 at risk?
3 A. Absolutely it did.
4 DR. MAXWELL: And that you were proved right because
5 there were incidents on those wards? 14:59
6 A. Yeah. There was, yeah.
7 DR. MAXWELL: And do you know if that was brought to
8 the attention of the Director of Nursing that this
9 decision had had this impact?
10 A. No, I don't think it was. I never got speaking to the 14:59
11 Associate Director of Nursing again after that. I
12 haven't -- I wasn't speaking to her since that day.
13 286 Q. MR. McEVOY: The impression one gets reading what you
14 say in that paragraph and, indeed, what you've just
15 sort of summarised in your oral evidence a moment or 14:59
16 two ago, is that management wanted assurances about
17 PICU so that there would be someone to blame if
18 something else went wrong?
19 A. Yeah.
20 287 Q. Is that the impression you intend to convey? 14:59
21 A. Mhm-mhm. But my management, and always was of that
22 opinion, no matter where I managed, I felt responsible
23 for every ward within Muckamore Abbey Hospital, and
24 every patient, and I think most staff that come in in
25 there, you've a responsibility, whether it's a caring 15:00
26 responsibility, you're responsible for looking after
27 all the patients and all the staff to make sure they're
28 safe. And there's elements of risk that you have to
29 take, but knowingly to move people to put other areas

1 into it, you have to minimise that risk, and PICU was
2 the crisis at that moment.
3 288 Q. Yes.
4 A. But I was shocked that these people didn't realise the
5 crisis that was going on throughout this hospital. 15:00
6 289 Q. Yes.
7 A. Not just in the core hospitals. This was happening
8 throughout the whole of the hospital. And they didn't
9 know that! But then we'll worry about that next week.
10 If something serious happens in Donegore or Killead, 15:00
11 then we'll worry, but at least we're sure this weekend
12 it's going to be safe. It was more than frustrating.
13 And -- yeah, and I'm sure my reaction to it at the time
14 wouldn't have been the best either with it, but it was
15 very, very frustrating. 15:01
16 MR. McEVOY: Mr. Mills, those are my questions for --
17 A. And that's why I retired. Sorry. That's why I
18 retired.
19 CHAIRPERSON: Go on, tell us.
20 A. Yeah, that's why. You know, I put my notice and an 15:01
21 intention to retire, and then two weeks later I was
22 summonsed to a meeting with the Director of Social and
23 Primary Care, and the Director of Human Resources, and
24 said as a consequence of the Serious Adverse Incident
25 Review, which again I didn't get speaking at, they felt 15:01
26 there was criticism of management and they would -- and
27 how soon could I retire, because they'd like to put a
28 new management team in. But I retired on the date I
29 was to retire on, the 28th November, and I took a few

1 weeks off sick leave, and then took my accumulated
2 leave. It was a sad way to go, I have to say, because
3 it was a fantastic place to work. No matter all the
4 faults and everything that you hear today, there was
5 good people worked, and there was fantastic relatives, 15:02
6 there was fantastic patients, and people that stayed
7 about for a while in there, they really thought a lot
8 of that place. And I just wish that the consultation
9 for the opening or closing of it had of waited until
10 the end of this Inquiry, because I just hope and pray 15:02
11 that the relatives and the people that I've over the
12 years that had serious difficulties and lack of support
13 in the community setting, and had nowhere to go, have
14 that support, and I hope that the Department of Health
15 can give them that assurances that they have the 15:02
16 support, and people going in there, because families
17 were broken. And we got a lot of things wrong, and I
18 got a lot of things wrong, but I wouldn't have had the
19 career that I had if I hadn't had them patients that
20 were there, and the good people that worked in it. 15:02
21 CHAIRPERSON: All right.
22 A. And I hope youse can do something about it anyway in
23 the long run for them.
24 CHAIRPERSON: Well, thank you. Can I thank very -- oh,
25 no, I can't thank you very much yet, because we've got 15:03
26 to move to a restricted part of the transcript. I
27 don't think that will take us very long. I'm going to
28 -- I think it's easier if we just sit. We can cut the
29 feed, please, to Room B, and can we change the

1 transcript straight away? Yeah. So we just carry on.
2
3 RESTRICTED SESSION
4
5 OPEN SESSION 15:03
6
7 CHAIRPERSON: All right. I don't think we've got any
8 questions arising out of that. So, it is left to me,
9 therefore, to thank you very much. You've given a
10 significant amount of your time, I know, to making a 15:13
11 statement, and to coming and assisting us this morning
12 and this afternoon. So can I thank you very much
13 indeed on behalf of the Panel. And I can now invite
14 you to leave with the Secretary to the Inquiry. Thank
15 you very much. 15:14
16 A. Thank you for asking me. Thank you.
17 CHAIRPERSON: We have to take a short break now. I
18 doubt very much we're going to be able to finish the
19 next witness. I will sit slightly later if there looks
20 like there's some chance of doing so, but it has been a 15:14
21 long day for everybody, especially for the
22 stenographer. Okay. We'll stop now for 10 minutes.
23
24 A SHORT ADJOURNMENT
25 15:14
26 THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS
27 FOLLOWS:
28
29 CHAIRPERSON: Thank you.

1 MS. BERGIN: Good afternoon, Chair and Panel. The next
2 witness is H189, and the internal statement reference
3 is STM-265.
4
5 Chair, you granted a Restriction Order already in 15:28
6 relation to this witness on the 31st May, and that's
7 RO76, and that's that the witness will be referred to
8 by cipher. There is now an application for a further
9 Restriction Order, and I propose to make that
10 application now. So I would to protect the application 15:28
11 for the feed to be cut in the usual way.
12 CHAIRPERSON: Yes. I make the usual order to cover for
13 this application.
14 MS. BERGIN: Yes. Thank you. And for the feed to be
15 cut also. 15:28
16 CHAIRPERSON: It's done automatically now.
17 MS. BERGIN: Yes. Thank you.
18
19 RESTRICTED SESSION
20
21 OPEN SESSION
22
23 CHAIRPERSON: Okay. Let's get the witness in.
24
25 H189, HAVING BEEN SWORN, WAS EXAMINED BY MS. BERGIN AS 15:30
26 FOLLOWS:
27
28 CHAIRPERSON: H189, can I thank you very much for
29 coming to assist us. You'll be referred to by that

1 cipher throughout. Can I apologise also for the delay
2 that you've had sitting in that room, I imagine that's
3 not very comfortable either. We're going to get as far
4 as we can with your evidence and hopefully finish you
5 this afternoon, but if that's not possible I understand 15:31
6 you can return tomorrow morning.
7 A. That's correct, yes.
8 CHAIRPERSON: All right. Thank you very much indeed.
9 MS. BERGIN: Thank you, Chair.
10 290 Q. Good afternoon, H189. As you know, my name is Rachel 15:31
11 Bergin and I am one of the Inquiry counsel. We've met
12 briefly and I've explained to you how we'll be dealing
13 with your evidence this afternoon.
14
15 You should have in front of you two documents. First 15:32
16 of all your statement, which is dated 29th May 2024,
17 and you have signed the Declaration of Truth at the end
18 of that document. Are you content to adopt that
19 statement as your evidence to the Inquiry?
20 A. Yes, I am. 15:32
21 291 Q. And you should also then have a cipher list in front of
22 you, and where a member of staff or patient has been
23 referred to by cipher in your statement, if you could
24 also refer to them the same way in your evidence, and
25 if you need to refer to any other staff or patients, as 15:32
26 I've already explained, if you could also try and find
27 their cipher or, if in doubt, just ask the Secretary
28 who will be able to assist you.
29

1 Finally, you will see we have a stenographer here, so
2 if you could try and speak as slowly and as clearly
3 into the microphone as you can, and if you need a break
4 at any stage, please indicate that?
5 A. Okay. 15:32
6 292 Q. All right.
7 CHAIRPERSON: I'm sorry to interrupt. Has the feed to
8 Room B been resurrected? Yes.
9 MS. BERGIN: Thank you, Chair.
10 293 Q. I am going to ask you about your statement in three 15:33
11 sections. All right. So we'll look at specific topics
12 in your statement first of all, and then we'll move on
13 to the specific topic of resettlement, and then finally
14 we will have a restricted session, and I've explained
15 to you already what that relates to. 15:33
16
17 To provide some context to your evidence, we won't be
18 reading your statement aloud, all of the Core
19 Participants and the Inquiry Panel have seen it, but
20 you outline a long history of working at Muckamore in 15:33
21 various roles from 1997 to 2017, isn't that correct?
22 A. That's correct, yes.
23 294 Q. And initially you worked, you state at paragraphs 1 and
24 5 of your statement, as a bank nursing assistant in
25 1997, and at that stage you were doing ad hoc direct 15:33
26 patient care, so hygiene or feeding tasks, and
27 supervision, and you say you didn't have any learning
28 disability training or experience at that stage. Did
29 you get any training when you were at Muckamore in 1997

1 in learning disability?
2 A. I can't recall specifics from 1997. I recall having an
3 induction book provided by the hospital where I would
4 have received an induction at each ward I went to for
5 the first time, and that would have included 15:34
6 information on the particular running of that ward and
7 pen pictures of the patients. I would have had I
8 suppose mandatory training in infection control and
9 manual handling.
10 295 Q. Just -- not to cut across you, but just I suppose you 15:34
11 started off your answer by saying that you couldn't
12 recall exactly, and I suppose just to focus your
13 answer. Can you recall receiving any specific learning
14 disability training at that stage?
15 A. No. 15:35
16 296 Q. Okay. Then after your time as a nursing assistant at
17 Muckamore, you then left and you qualified with a
18 diploma in learning disability nursing in 2000 from
19 Queen's University Belfast?
20 A. That's correct. 15:35
21 297 Q. Yes.
22 A. I would have -- the bank nursing post, I would have
23 continued that during my training as well, because it
24 wasn't -- it was zero hours effectively, so you could
25 have done a bank shift as and when they were available, 15:35
26 and you were free do them.
27 298 Q. All right. And you then returned in 2000 to Muckamore
28 as a nurse then, and you worked as both a substantive
29 nurse and also a bank nurse, and I think it's correct

Gwen Malone Stenography Services Ltd.

1 that your first role at Muckamore in 2000 as a nurse
2 was as a Staff Nurse on Movilla A and, you also worked
3 on Moylena, and you were in the role of Staff Nurse at
4 Muckamore between 2000 and 2008, and is it correct that
5 during this time in 2006, that's when you trained as a 15:35
6 MAPA instructor?
7 A. Yes, that's correct.
8 299 Q. And following that, you then became a Charge Nurse and
9 you worked in Fintona North and Donegore between 2008
10 and 2012? 15:36
11 A. Yes.
12 300 Q. And you then became a nurse development lead in 2012
13 and you were in that post until 2014?
14 A. That's correct, yes.
15 301 Q. And you then moved into management, and you were an 15:36
16 Operations Manager for community resettlement from 2014
17 to 2017?
18 A. That's correct, yes.
19 302 Q. And you then left Muckamore in 2017?
20 A. Yes. 15:36
21 303 Q. And throughout your statement you outline various
22 topics, including, MAPA, care plans, patient risks,
23 assaults on staff, governance, your involvement in CCTV
24 review, and also resettlement, and you say at paragraph
25 132, in terms of your general reflections of your time 15:36
26 at Muckamore that staff and patients appeared happy
27 when you were there.
28
29 "Whilst some staff saw working at Muckamore as a job

1 and wouldn't have done anything outside of their
2 requested roles, the majority of staff cared for
3 patients and their families and worked beyond their
4 required roles to nurture a quality of life as best as
5 possible within a hospital setting." 15:37
6
7 Isn't that correct?
8 A. That's correct, yes.
9 304 Q. So you have described in your statement, which we'll
10 come to various parts of it now, a broad range of 15:37
11 experience, both as a nurse and also in management.
12 And if we could then look to begin with paragraph 16,
13 please.
14
15 Now, from paragraph 16 onwards, just while we're 15:37
16 getting it up on the screen, one of the key issues
17 which seems to come across in your statement is that
18 staff were very engaged in ensuring that there where as
19 many opportunities for patients as possible, and you
20 describe at paragraph 16 outings to the zoo, hotel 15:38
21 trips, and supporting patients to prepare their own
22 meals, and staff even coming in on days off to take
23 patients out.
24
25 In your experience, did this have a positive effect on 15:38
26 patient's behaviour and then lessen the likelihood of
27 dysregulated behaviour?
28 A. Yes, I think overall a more positive quality of life
29 results in more positive outcomes in terms of

1 behaviours. I suppose one of the things that sometimes
2 we would have seen following outings, particularly with
3 some patients who maybe had some trauma, traumatic
4 experiences in their life, was that maybe following an
5 outing, that there might have been an escalation in 15:38
6 behaviours, and I think sometimes you put that down to
7 they maybe perceived a demand that they would have to
8 enjoy themselves, or they would have had to have had a
9 good time, and it was difficult for them to cope with,
10 given their traumatic past experiences in life. But I 15:39
11 think overall it stands to reason that if you improve
12 somebody's quality of life, you're going to see less
13 challenging behaviours.
14 CHAIRPERSON: Could I just ask you to keep your voice
15 up. You've got quite a soft voice. 15:39
16 A. I'm sorry. I'll move closer.
17 305 Q. MS. BERGIN: If we look at paragraph 21 then, and here
18 you describe 2018/2019 as being a stressful period, and
19 you describe changes in staff management, increasing
20 suspensions and staff sickness, and media coverage and 15:39
21 demand then for assurances, and you in fact describe
22 this as taking a personal impact on your mental health.
23 Did staff at Muckamore receive any support during this
24 time of stress or difficulty.
25 A. I'm aware that there was a counselling service started 15:40
26 at Muckamore. I'm not aware of the exact date when
27 that started. I suppose in terms of the wider staff
28 population, the supports they would have received would
29 have been through their line management. I certainly

1 felt myself that I spent a lot of time having
2 conversations with staff trying to support them, and
3 I'm sure my other colleagues at 8A level did likewise.
4 I understand that there was some information circulated
5 from psychology colleagues at the time in terms of 15:40
6 staff checking their well-being before leaving shift.
7 That's all I can recall at this point.
8 306 Q. And are you aware, for example, of any types of
9 structured check-ins with staff during this time that
10 were organised by management, for example? 15:41
11 A. There would have been visits on-site by the director at
12 the time, and I'm not sure if she's on the cipher list?
13 And the Executive Director of Nursing. No, she's not.
14 CHAIRPERSON: I think show it to counsel probably.
15 INQUIRY SECRETARY: I'll just check. 15:42
16 307 Q. MS. BERGIN: Thank you. I think I have those and I can
17 provide them to the Panel afterwards, but you can just
18 refer to them by their titles for now.
19 A. Okay. So there was the Director for Learning
20 Disability Services, and the Executive Director of 15:42
21 Nursing, and there would have been information sessions
22 for staff in the hospital.
23 308 Q. We are jumping around somewhat, but when we're on the
24 topic of directors and management attending, if we
25 could look at paragraph 36, please? Now, here you 15:42
26 state, and I'll begin reading while we wait for the
27 statement to come on screen:
28
29 "Everyone was responsible for their own areas which

1 meant that the management was siloed when it came to
2 day-to-day running of the hospital. Senior managers
3 would not ordinarily have visited wards which they were
4 not responsible for."
5 15:43
6 And you then go on to say that:
7
8 "Having seen the increase in people appointed to senior
9 overarching roles since 2017, it seems logical to think
10 that there was not enough direct contact at co-director 15:43
11 and director level within the hospital."
12
13 And at paragraph 104, you then go on to say that you
14 saw hospital based management regularly several times
15 per week, but you cannot recall seeing members of the 15:43
16 Belfast Trust Board.
17
18 So when you say that you saw hospital managers
19 regularly, who are you referring to there?
20 A. I suppose that section of my statement was relating to 15:43
21 an early period in my career. So the hospital based
22 management then would have been the Senior Nurse
23 Managers and the Site Manager, the Service Manager at
24 the time.
25 309 Q. And when you say that was in the early period, was that 15:44
26 frequency then something that continued throughout your
27 time, or how did that change, if at all?
28 A. I think it changed -- I suppose I became one of them
29 managers later in my career -- but I suppose it

1 changed, from my recollection, with the opening of the
2 new hospital, and there was a sort of change in the
3 roles where you had managers for the new hospital and
4 then managers for the resettlement wards. My
5 experience prior to that would have been seeing senior 15:44
6 nurse managers coming around, doing rounds as you were,
7 coming round all the wards on different days, and I
8 think after that, after the opening of the new hospital
9 that didn't happen as much. So, I suppose from my
10 point of view whenever I was -- my roles were slightly 15:45
11 different in that I was in the resettlement programme,
12 so I was visiting the resettlement wards, I would have
13 had less contact with the core hospital wards, simply
14 because there wasn't the same amount of patients in
15 there who were on the PTL list or delayed discharge at 15:45
16 that time.
17 310 Q. All right. If we can look then at paragraph 22,
18 please? And we're dealing with patient behaviour here,
19 and we don't need to go to it, but by way of
20 background, in paragraph 17 you refer to incentive 15:45
21 plans that were in place that you saw at Movilla in the
22 late 1990s and 2000s, where patients could earn rewards
23 and get tokens.
24
25 So then at paragraph 22 you say that you were 15:46
26 uncomfortable with this token economies model of care
27 which was in place earlier. You say that this was a
28 form of behaviour modification based on the idea that
29 patients could earn things through displaying desired

1 behaviour or refraining from undesirable behaviours,
2 and you say that:
3
4 "Many of us would struggle to exhibit desired
5 behaviours if forced to live in environments 15:46
6 intolerable to us and with strangers."
7
8 And that you're glad that model evolved. Rather than
9 perhaps having the desired effect of improving
10 behaviours, do you think that that model of behaviour 15:46
11 modification in fact increased patient frustration and
12 aggressions?
13 A. I think in some cases it did, yes. On individual
14 levels for some patients. I certainly seen patients
15 who would have got to a point say on a Wednesday where 15:47
16 there was just no way that they would have earned
17 enough tokens or points to get their weekly reward come
18 Friday, and it was, despite their best efforts from the
19 rest of the week, when they came to reviewing it with
20 them on the Friday, seeing the upset that it caused for 15:47
21 them, and maybe on occasions it would have elicited an
22 angry response and further challenging behaviours and,
23 again, you were in the counselling patients concerned
24 that they would maybe end up displaying a behaviour
25 that would nearly lose them their points for the 15:47
26 following week that was about to begin. So there were
27 challenges with that model I think.
28 311 Q. And what was it then replaced by and what was your
29 impression of that?

1 A. I suppose there has been a process of change with it.
2 I think the first stage of change with that model was
3 that it was changed so that people wouldn't lose tokens
4 that they had earned, or points, or however it's best
5 described, so that they could still continue, so that 15:48
6 move to rewarding the desired behaviours as opposed to
7 focusing on the behaviours that were more challenging,
8 I think of where we're at now, it's been replaced with
9 a Positive Behaviour Support plan, and that ethos
10 throughout services, which I suppose recognises that 15:48
11 rather than having people earn a quality of life, that
12 it's important that everybody has an improved quality
13 of life and a better quality of life, but also provide
14 people with the opportunities to develop skills to help
15 them behave differently. 15:48
16 312 Q. All right. If we could now look at CCTV, and paragraph
17 20, please? We're going to first of all look at
18 contemporaneous CCTV viewing and then historic. So at
19 paragraph 20 you say that around November 2017, in your
20 capacity as the Senior Service Manager, you and other 15:49
21 managers were tasked with viewing CCTV as a means of
22 providing assurance about patient care and treatment,
23 and your role was to view the CCTV, fill out the sheet,
24 raise concerns, if you had them, and then leave the
25 sheet with H351. The Inquiry has heard about CCTV 15:49
26 viewing forms, is that the sheet you're referring to?
27 A. Yes, I expect that it is.
28 313 Q. And can I --
29 A. Although there probably would have been different forms

1 for the historical viewing that would have been done
2 alongside safeguarding officers, and the
3 contemporaneous viewing that I would have undertaken
4 with other Senior Nurse Manager colleagues.
5 314 Q. And do you know who designed those viewing forms that 15:50
6 you were dealing with?
7 A. I don't know for certain who designed them. I know who
8 provided them, and that was H351.
9 315 Q. Yes. And you go on to say then that H351 in fact
10 coordinated the viewings, and that H351 and H507 15:50
11 directed the Assistant Service Managers to do these
12 viewings, and you say that you had to watch a certain
13 amount of time from the previous day or week, which was
14 randomly allocated from random cameras and random
15 times. Do you know who decided what periods you were 15:50
16 to view at all, or was it entirely random in terms of
17 the allegation?
18 A. I think it was random in that I don't think we were
19 given specified times. I think it was -- we were to
20 view a 15-minute period from a morning and afternoon 15:51
21 and early evening from the day previous, or what often
22 happened, it started to back up, so you're maybe
23 looking at footage from 3 to 4, to 7 days previously.
24 But I suppose it was at the discretion of us as viewers
25 to pick which 15-minute period and I think which camera 15:51
26 to look at.
27 316 Q. Okay. And you've said that one of the timeframes was
28 the evening. Now the Inquiry has heard some evidence
29 in relation to a lack of viewing overnight. Whenever

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1 you refer to "evening" are you also referring to
2 overnight?
3 A. I can't recall. I suppose, yes, so we would have
4 viewed overnight periods, and, yes, morning, afternoon
5 and night-time. 15:52
6 317 Q. How often were you asked do this and for how long? So
7 you've said that the ask came in around November 2017?
8 A. I think we were still being asked do it at least until
9 March or April of 2018, and we were being asked to do
10 it on a daily basis, on a regular basis, and there was 15:52
11 a rota. I did ask -- I did raise on a number of
12 occasions the amount of time it was taking to view it,
13 the time it was taking myself -- well, I suppose I
14 asked in terms of myself, that it was taking me away
15 from my substantive post as well and queried how long 15:53
16 this would be going on for and if there was other
17 people who could come and support the process so that
18 it was spread out.
19 318 Q. The Inquiry has heard evidence in relation to how
20 viewing was carried out. What were the viewing 15:53
21 arrangements for you in terms of were you viewing it by
22 yourself, with others, what was the setup with the
23 computer screens and viewing it?
24 A. Yeah. I think initially the viewings were undertaken
25 in -- there was some sort of a comms room in Cranfield, 15:53
26 and one in Six Mile, where I suppose the computer
27 system was based for the CCTV, and that's where we
28 would initially have done the contemporaneous viewing.
29 319 Q. So it was ward based rather than in admin buildings,

1 for example?
2 A. Yes, it was ward based, yes. So we had to go over to
3 Cranfield or Six Mile to do that.
4 320 Q. And in terms of how you viewed it, did you view it
5 alone? This is contemporaneous. Did you view alone 15:54
6 or...
7 A. Oh, yes. No, we viewed it in pairs together. It would
8 have been myself and a colleague. So two 8As at a
9 time. I think the direction was that one would view
10 it, would view it, and if there was a concern, the 15:54
11 second one was there to view it as well and check it.
12 But if there's nothing of concern, it was sufficient
13 for one person to view it.
14 321 Q. And in terms of the extent of your involvement, so
15 after you filled in the form and I suppose left the 15:54
16 sheet, as you say in your statement, to H351, if you
17 flagged a safeguarding concern or an inappropriate use
18 of MAPA, and we'll come to that in a moment, was that
19 the end of your involvement handing the sheet over, or
20 did you have any follow-up? 15:54
21 A. No, that was the end of our involvement once we handed
22 the sheet over.
23 322 Q. Okay. If we can now then look at paragraph 21, please,
24 and we're moving on then to historical CCTV viewing?
25 A. Okay. 15:55
26 323 Q. And you say here that you were asked by H287 and H507
27 to assist with the historical safeguarding
28 investigation by viewing CCTV alongside the
29 safeguarding team, and you were particularly asked to

1 provide MAPA commentary about the application of MAPA
2 training on some of the footage, and we've already
3 heard that you were MAPA trained as an instructor, and
4 you say in your statement that you were one of the MAPA
5 trainers in Muckamore. So, in terms of this type of 15:55
6 CCTV viewing, this began when in 2018?
7 A. I can't remember when that commenced.
8 324 Q. Can you recall how long you were involved in this for?
9 A. I think I was involved up until I took a period of time
10 off, which would have been in and around April of 2018. 15:56
11 325 Q. And at the time that you were providing this MAPA
12 input, were you the only person providing MAPA input?
13 A. Yes. To my knowledge, yes.
14 326 Q. And if we look at paragraphs 26 and 27 then, you say
15 that you felt uncomfortable sometimes viewing 15:56
16 non-contemporaneous or historic CCTV with the DAPOs,
17 because the DAPOs would have said footage showed abuse,
18 but you did not see it like that. You saw that staff
19 were managing patient movements which may have been
20 unsafe and it would not have been possible to determine 15:56
21 in all cases from CCTV footage alone who was creating
22 the movement, and you say that when you felt
23 uncomfortable with incidents on CCTV, you spoke to
24 DAPOs viewing it alongside you, and you also say that
25 there were confidentiality issues around CCTV, and it 15:57
26 was tight in terms of who could see it, and you
27 therefore found it difficult because you didn't know
28 who you could speak to.
29

1 So you've said you were sometimes uncomfortable with
2 viewing CCTV. How do you think the CCTV viewing could
3 have been better handled?
4 A. I suppose I felt uncomfortable with the footage that I
5 was viewing. 15:57
6 327 Q. Rather than the process?
7 A. Rather than the process.
8 328 Q. Okay. You've referred then to, the section I've read
9 out, I suppose the difference of view in terms of what
10 you and the DAPOs were seeing. How were differences in 15:57
11 interpretation between the DAPOs and nurses like
12 yourselves or managers like yourselves managed?
13 A. I suppose where we had a difference, and I think I
14 mention it in my statement where if I had said
15 something I thought that maybe it didn't or was 15:58
16 familiar with the MAPA training, I think it was the
17 view from the DAPOs at the time 'Well, this has already
18 been referred for safeguarding. So if everything is
19 okay then that will come out in the investigation'. So
20 the footage I was viewing had already been referred for 15:58
21 safeguarding, so I was a little bit unsure. It made me
22 a little bit unsure as to why I was viewing at that
23 point and where, where it was in terms of the
24 investigation process, and who with. I thought if
25 there was something in relation to a question about 15:58
26 MAPA in the investigation process -- I don't know where
27 we were in the investigation process at that point.
28 329 Q. Okay. And you in fact touch on that exact point in
29 your statement at paragraph 29. You've said you're not

1 sure. Thinking back to that time, why did you think
2 you were asked to review the CCTV and provide MAPA
3 input, or were you simply unclear?
4 A. I suppose at the time I thought it was to help decide
5 whether something would go to a safeguarding referral 15:59
6 or not, but I suppose upon doing them viewings and them
7 conversations, it was made clear to me that they had
8 already been referred for safeguarding, so I wasn't
9 sure what the purpose was at that point.
10 CHAIRPERSON: Can I just ask, did you see a clip that 15:59
11 you knew had been referred to safeguarding and you
12 thought it shouldn't have been?
13 A. I think the majority of footage that I seen, I think it
14 warranted a referral and investigation. I think there
15 was a small number, and I described some of them, 16:00
16 there's one in my statement, where I didn't think that
17 it was a safeguarding because it was the patient who
18 had actually moved towards the staff member as opposed
19 to the staff member moving towards the patient, and
20 subsequent actions after that would have been as per 16:00
21 the training.
22 CHAIRPERSON: Yes.
23 DR. MAXWELL: So are you saying that interpreting the
24 staff action depended on whether the patient had
25 initiated the movement or the staff had initiated the 16:00
26 movement?
27 A. I think I tried to look at every part of it in line
28 with the training. So whilst watching that piece of
29 footage, the DAPO, I recall the DAPO and H351 saying

1 that he's pushed him there, he's pushed him, but after
2 viewing the footage a number of times, what the staff
3 member had been doing was putting her hand out to
4 suggest to the patient that here's a boundary, please
5 don't come... 16:01
6 CHAIRPERSON: And on that occasion did you all come to
7 an agreement, as it were, that it wasn't a referral?
8 A. It had already been referred, and I think that was one
9 of the....
10 CHAIRPERSON: So what did you do about that? 16:01
11 A. I suppose there was nothing that I felt that I could
12 do, other than allow the...
13 CHAIRPERSON: Right.
14 A. And I suppose that's part of the -- I was reassured
15 that it's okay, not everything has to be immediately 16:01
16 apparent as abuse to go for a safeguarding referral.
17 If people have a concern they're right to put it
18 through as a referral, and if it turns out on
19 investigation that it wasn't safeguarding...
20 CHAIRPERSON: Yes. Okay. 16:02
21 A. And I never heard anything further after it. So I can
22 only assume that it's probably still under
23 investigation.
24 DR. MAXWELL: When you were asked to look at these
25 clips, did you have the patient notes with you? Did 16:02
26 you have any contextual information or were you just
27 looking at the video clip with no context?
28 A. There was no context at all. There was no patient
29 notes. And in fact, I understand nobody had looked at

1 any notes at any stage prior to viewing the CCTV. It
2 was purely just looking at the CCTV as a standalone.
3 CHAIRPERSON: Thank you.
4 330 Q. MS. BERGIN: Did you ever ask to see notes?
5 A. I can't remember if I did. 16:02
6 331 Q. You've said that you were being asked to provide a view
7 on MAPA after a safeguarding referral had already been
8 made. Do you think that there should have been some
9 form of MAPA expert input earlier in the process at the
10 stage that the CCTV was first being reviewed and 16:03
11 safeguarding referrals were being considered?
12 A. Yes, I thought that's what I was doing. It was at that
13 earlier stage before the referral had went in.
14 332 Q. All right.
15 A. I'm not sure it would have changed. 16:03
16 333 Q. Apologies.
17 A. Sorry. I'm not sure it would have changed the majority
18 of referrals. I think a lot of them would still needed
19 to have gone for investigation.
20 334 Q. All right. If we could then look at admissions and go 16:03
21 to paragraph 43, please? And I'll begin to read. Here
22 you say that:
23
24 "At the beginning of my career in Movilla A I would not
25 necessarily have been aware of the reasons for each 16:04
26 patient's admission."
27
28 And you go on to say that:
29

1 "More often the admission was due to risky behaviours
2 and I do not think that it was always clear what the
3 purpose of the admission was and what it was hoped to
4 achieve."
5 16:04
6 Do you think the ability to provide care was effected
7 or made more difficult by not knowing what the reason
8 for the admission was?
9 A. I would say, yes. I think it was difficult when there
10 was an expectation that behaviours would change, 16:04
11 behaviours that have been longstanding and maybe
12 chronic in somebody's life, that they would change as a
13 result of coming into hospital. I suppose there
14 wouldn't have been as much awareness, I don't think in
15 my time as Movilla A, about -- in terms of in-depth 16:05
16 formulations of behaviours, about sensory needs, about
17 recognition of trauma, and certainly it would have been
18 quite limited in terms of people were generally
19 medicated, and then, if appropriate, they were provided
20 with a behaviour incentive plan, but it wasn't always 16:05
21 apparent to me what was going to be achieved by people
22 being in hospital.
23 335 Q. And was that at your experience, you've said that that
24 was at the early part of your career, was that your
25 experience throughout your time? 16:05
26 A. Yeah, I think so. I certainly recall occasions where
27 people would have been assessed in the community by
28 their community consultant or psychiatrist, maybe of an
29 afternoon, and then after 5:00 o'clock in the evening

1 that person was maybe detained out-of-hours and
2 transferred to hospital because they were still
3 displaying risky behaviours. So they were essentially
4 admitted into a hospital for a mental health issue when
5 they had just been reviewed by their psychiatrist maybe 16:06
6 that afternoon.
7 336 Q. Okay. And if we could go to paragraph 48, please? You
8 say here then after admission, after the first few
9 weeks, your role in relation to assessing the patient
10 was that you completed the care plan and the activities 16:06
11 of living and nursing care plan. When you were
12 completing care plans for new admissions, did you
13 engage with families?
14 A. Yes, I would have spoke to families and gotten a
15 history from them. I suppose my role in Movilla A, 16:07
16 that was reasonably limited. I primarily would have
17 been the named nurse's role, and I suppose it's a bit
18 different nowadays where you would be a named nurse for
19 a patient nearly straightaway, but back in 2000 you
20 nearly had to be working six months to a year before 16:07
21 you would take on that role. It was usually somebody
22 much more experienced and much more senior who would
23 have been the named nurse.
24 337 Q. Moving then on to patient experience and learning from
25 patient's experience. If we could look at paragraph 16:07
26 59, please? And here during your time as nursing
27 development lead, you say that you introduced quality
28 questionnaires, and you say:
29

1 "These gauged the patient experience about meal times,
2 including the quality of food, feedback on food
3 appearance, environment, noise, and any other aspect of
4 meals was sought."
5 16:08
6 Was this feedback actually acted upon?
7 A. Yes. I mean I suppose again to give a bit of context
8 to that, it was a very limited -- that was only done
9 within two wards.
10 338 Q. Do you mean done by you, or was there any wider patient 16:08
11 feedback experience?
12 A. No, it wouldn't have been done by me. I facilitated
13 the teams to do it.
14 339 Q. Okay.
15 A. And then out of that developed an action plan which 16:08
16 enabled them to look and reflect upon what the meal
17 times might be like. So it was a wee bit of -- I
18 suppose it comes back to trying to consider things that
19 maybe didn't always consider in terms of a quality meal
20 time. There's not many of us sit at home and have our 16:09
21 meal with noise in the background, or dishwashers
22 running, or things like that, or even so much as
23 traditionally meal times would also have coincided with
24 medication rounds, and thinking about how you're
25 interrupting somebody's meal to give them medication, 16:09
26 was some of the things we found out. But, again, it
27 was a very limited sample. It was introduced. I don't
28 think it was something that ran very often --
29 340 Q. Apologies. I didn't mean to cut across you. Did you

1 observe any though changes off the back of that?
2 A. I suppose I can't say that I observed any changes that
3 sustained, and I suppose I wasn't in the wards daily to
4 see if it sustained.
5 341 Q. If we could then move on to seclusion and MAPA, and 16:10
6 paragraph 70, please? And here you say that:
7
8 "There were seclusion rooms in Movilla A and Fintona
9 North and then in later years PICU created a seclusion
10 suite off the ward and away from others. There were 16:10
11 seclusion areas developed in Six Mile Ward due to one
12 patient requesting this."
13
14 Just to clarify, is it the case that all of those
15 seclusion rooms or wards were open at once, or was it 16:10
16 that Movilla A and Fintona closed and then -- the
17 seclusion rooms -- and then the other two were opened
18 afterwards?
19 A. That would be correct, yes.
20 342 Q. Apologies, which part? 16:10
21 A. Yeah, so I'm just reading. So PICU -- Movilla A
22 closed, and PICU was opened. So they wouldn't have
23 been going at the same time. Fintona North was still
24 open until 2009, so there would have still been
25 seclusion up in Fintona North up until February 2009. 16:11
26 And I think PICU was operational from around about
27 2006.
28 343 Q. If we look at paragraph 71 then, the next paragraph
29 down in relation to MAPA, and here you say that you

1 trained a lot of the staff in Muckamore and you
2 satisfied yourself that they were able do the
3 appropriate MAPA in a classroom setting. You then say:
4
5 "When I was doing training, people frequently got 16:11
6 things wrong, which is the purpose of training."
7
8 You continue:
9
10 "The safeguards that we had, if they were not getting 16:12
11 it right in the classroom and needed support, was that
12 I spoke to the Ward Manager."
13
14 A. That's correct. We would also have filled out an
15 individual assessment form, and that would have been 16:12
16 forwarded to the Ward Manager, and a copy to the
17 Assistant Service Manager at that time. I suppose in
18 2006 the model was slightly different, there wasn't the
19 same -- I don't know if I go into that detail? In 2006
20 MAPA was owned by a different company, and there wasn't 16:12
21 the same documentation and paperwork provided within
22 the training, that came roundabout 2013, that would
23 have been introduced.
24 344 Q. And you've indicated that in 2013 it was more detailed.
25 In terms of, I suppose some of the detail around that, 16:12
26 you're saying that if staff weren't getting it right in
27 the classroom you would have spoken or notified the
28 Ward Manager, and there would have been paperwork.
29 Were staff allowed to use MAPA if they were getting it

1 wrong in the classroom, or did you have to satisfy
2 yourself that they had got it right in the classroom
3 before they were then certified to actually use it on
4 the wards?
5 A. Yes, that's correct. I mean people weren't getting it 16:13
6 right as part of the training, and that's what the
7 training was for, it was to help tidy up and instruct
8 them on that. So by the end of the course,
9 particularly on a five day course, you would be
10 satisfied, or I would be satisfied that people were 16:13
11 able to demonstrate the principles correctly within the
12 classroom setting, and I suppose that was the threshold
13 for us, it was within the classroom setting, it wasn't
14 in sort of real-life scenarios where there was
15 different elements of risk, and fear and stress and 16:13
16 anxiety.
17 345 Q. Did it ever, your training, did that ever -- we're
18 going to come to this in a moment in relation to
19 movement to the Datix fields, but did your training
20 ever involve observation, like spot-check observations 16:14
21 on the wards or anything like that?
22 A. No, I didn't. Although I would say in Muckamore we
23 were quite unique in that we invested heavily in the
24 MAPA programme, and had an instructor based on each
25 ward. It's not that there was an instructor based on 16:14
26 each ward, there was somebody employed in each ward who
27 also had undertaken the training to be an instructor.
28 So that was, I suppose, part of our thinking about in
29 terms of reassurance, and that's, for staff, there was

1 somebody at a ward level who they could speak to on a
2 daily basis if they had queries or questions.
3 346 Q. You trained as a MAPA instructor in 2006, and you were
4 -- certainly before you went into your management role
5 you were in nursing role where you've described your 16:15
6 involvement in MAPA training. Where there any
7 opportunities to provide refresher training, or was it
8 simply that staff were given one MAPA course and that
9 was then?
10 A. No, there was a requirement for staff to update 16:15
11 annually, and that was -- there may have been slight
12 variations in that, in there was maybe a wee bit more
13 licence in the earlier time periods for that. So maybe
14 being able to extend out to 18 months. But certainly
15 in around the time I finished delivering training, it 16:15
16 was very stringent that it had to be within 12 months,
17 that update. As instructors we always had to update
18 within 12 months.
19 347 Q. And do you know was there somebody whose job it was to
20 ensure that everyone had signed off on their MAPA 16:15
21 training for the year, in terms of enforcing that?
22 A. I suppose for me the responsibility for staff training,
23 that falls within the remit of the Ward Sister or
24 Charge Nurse, whether that be MAPA training or any
25 training. 16:16
26 348 Q. Okay.
27 A. So for me that's the responsibility of the Ward Sister
28 or Charge Nurse to train. As instructors we train
29 whoever was booked on to training, whoever sat in the

1 room.
2 349 Q. All right. If we can then look at paragraph 74,
3 please? And here you outline that you were involved in
4 a working group that transferred the physical
5 intervention record process -- 16:16
6 DR. MAXWELL: Before we move on, while we're still on
7 MAPA, you said that every ward had a designated MAPA
8 lead. Is that right?
9 A. There was an instructor on each ward.
10 DR. MAXWELL: There was an instructor on each ward. So 16:16
11 I'm wondering, earlier in your statement in paragraphs
12 24 and 25, you say that you saw the non-contemporaneous
13 --
14 MS. BERGIN: Apologies. Apologies. If I could just
15 interrupt there. That's actually... 16:17
16 DR. MAXWELL: Oh, sorry. Sorry.
17 MS. BERGIN: No, not at all. Not at all. Thank you.
18 DR. MAXWELL: Sorry.
19 MS. BERGIN: No, not at all. We'll deal with that
20 later. Yes, thank you. 16:17
21 CHAIRPERSON: We'll come back to that.
22 DR. MAXWELL: My apologies.
23 MS. BERGIN: Not at all.
24 350 Q. So staying then on the MAPA theme, at paragraph 74 then
25 you have indicated that you were part of a working 16:17
26 group, and that was involved in transferring the
27 physical intervention records process from paper
28 records to Datix.
29 A. Mhm-mhm.

1 351 Q. And you say that you actually formed a working group
2 with MAPA instructors from Knockbracken Health Care
3 Park, and you created fields in the Datix system which
4 were for MAPA and then later seclusion. And you say
5 about this that: 16:17
6
7 "This enabled people to think about the incident and
8 what had been occurring prior to physical intervention
9 and then made the reporting function more useable. As
10 a MAPA trainer I looked at the reports and whether the 16:18
11 record of the physical intervention made sense in terms
12 of the context."
13
14 And we've already spoken about context earlier in terms
15 of CCTV viewing. When did this move from paper to 16:18
16 Datix take place?
17 A. We certainly started that work prior to 2014. I'm not
18 entirely sure. I think there were still some pieces to
19 finish off whenever I left the NDL post. So it was
20 probably sometime in 2014, possibly 2015. 16:18
21 352 Q. So it was live at least by late 2014 early '15, that
22 people could actually start inputting the data on-line,
23 could they?
24 A. I think so. I would need to confirm to clarify the
25 date. 16:19
26 353 Q. That's okay. We can follow up if we need to.
27 A. Yes.
28 354 Q. In terms of then what the purpose of that system, and
29 specifically having these new sections of MAPA and

1 seclusion, does that mean that every incident of MAPA
2 or every usage of MAPA, or seclusion, however brief,
3 was input into Datix or was meant to be input into
4 Datix?
5 A. Yes, and I suppose the thinking behind that was -- 16:19
6 there was a couple of reasons. One being that there
7 shouldn't have been the use of physical intervention or
8 seclusion unless there was an incident that had
9 occurred. So it was trying to frame that up as well in
10 terms of education for staff, that if they were talking 16:19
11 about last resort and least restrictive, you wouldn't
12 have a record, and I think there probably was a bit of
13 awareness required at the time, because people were
14 thinking they were filling out the Datix because there
15 was physical intervention, and was trying reframe with 16:20
16 people that you're filling out the Datix because there
17 was an incident, the physical intervention was part of
18 the management of that incident, but in itself it's not
19 or it shouldn't be the incident, the incident had to
20 have occurred for there to be a physical intervention 16:20
21 required. And, likewise, with the, at a later stage,
22 the seclusion.
23 355 Q. Was this simply modernising moving away from paper
24 moving to electronic on computer, or was there
25 something that prompted -- because you seem to be 16:20
26 describing more of a substantive change here rather
27 than just a difference in terms of how things are
28 recorded?
29 A. Yeah. I think there was an element of modernising.

1 There was an element of modernising. There was also an
2 element of -- there would have been monthly audits
3 undertaken by resource nurse or governance, H777, and
4 she would have been looking at incident numbers, and I
5 think... 16:21
6 356 Q. You can write the name down for the Secretary if that
7 assists?
8 A. I can't see it here. It was a fellow MAPA instructor
9 and a behaviour nurse would have reviewed the paper
10 audit forms that wards completed for if there had of 16:22
11 been the use of physical interventions, and when they
12 met, sometimes they weren't matching up, so you might
13 have had an audit form for a physical intervention
14 taking place, but there wasn't an incident form, and
15 this was, I suppose, part of thinking that people 16:22
16 weren't, they weren't seeing an incident where maybe
17 they were using physical intervention. So there was --
18 or sometimes there was an incident form, but no
19 physical intervention audit form. So there was a bit
20 of, I think differences sometimes in that, way down to 16:22
21 recording error. I don't know. So there was that
22 element of it. And then there was also the element of
23 modernising and improving the service. And I suppose
24 in my role as nurse development lead at the time, I was
25 becoming accustomed to using electronic or computerised 16:23
26 systems more, there was different computerised systems,
27 so I thought there was an opportunity to improve the
28 service by making the seclusion audit, or not
29 seclusion, the physical intervention audit forms as

1 part of the Datix and linking them together.
2 357 Q. If we actually look at paragraph 75 and then 79. At 75
3 on this topic you say that you think that the movement
4 from paper records to Datix meant more people had
5 access and there were increased opportunities for 16:23
6 analysis. You say that:
7
8 "Teams and people add Muckamore could look for patterns
9 and Datix then linked physical interventions to
10 incidents which was not previously done." 16:23
11
12 And at paragraph 79 you said that:
13
14 "Datix showed patterns of correlation between certain
15 times of day and incidents, and I was involved in teams 16:24
16 were there were increased incidents at staff
17 handover..."
18
19 And you then give an example of developing a plan for
20 patients on Donegore during staff handover to avoid 16:24
21 incidents at those times.
22
23 So you've referred to a member of staff already doing
24 some level of review or tracking of incidents prior to
25 this system coming in, were you then tracking, or was 16:24
26 another member of staff tracking these patterns and
27 analysing them after the system came in?
28 A. Yeah, it was still the same member of staff primarily.
29 I, at a later stage when it was on Datix, started

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1 getting -- I got access as well to review as part of
2 the implementation of it, so we were assured that
3 people were inputting the information correctly, and a
4 lot of that, you were giving feedback back to the
5 approvers, who were usually the ward managers, to say 16:25
6 'well, look, we've reviewed this form. Can you clarify
7 this part of the information on it?', and more often
8 than not it was things like an incident might have
9 started in the dining room and finished in a sitting
10 room, but when we talked about what the patient's 16:25
11 position was during the physical intervention, there
12 would be only one position recorded, which was sitting,
13 and it was just trying to raise with them -- I think
14 there was other fields that could you tick there to
15 give somebody viewing that an idea of what had 16:25
16 happened, because the person didn't sit the entirety of
17 the time from this room to this room, they would have
18 stood up, they would have walked, they would have sat
19 down. So it was getting people to make sure they were
20 filling out all of the fields correctly. 16:25
21 358 Q. Apart from qualitative element of ensuring that there
22 was consistency in the form, was anyone reviewing
23 periodically or for specific topics like the frequency
24 of MAPA with one patient, was anyone reviewing those
25 and feeding those into multidisciplinary team meetings 16:26
26 or elsewhere in the hospital?
27 A. There wasn't one singular -- well it wasn't myself, and
28 I don't think it was the other person. H777 would have
29 compiled monthly reports on the use of physical

1 intervention per ward, and there would have been a
2 breakdown across a number of different fields in terms
3 of time of day, duration, patients, and that
4 information would have been fed back into the clinical
5 teams multidisciplinary teams, and then also to the 16:26
6 senior governance group -- that may not be the correct
7 terminology or the correct name, but the senior
8 governance group in the hospital, which met monthly,
9 and they would have, as I understand it, considered
10 trends, and I suppose for me the clinical team at ward 16:27
11 level were looking at individuals, but they wouldn't
12 necessarily have required that information to be able
13 to understand that at a ward level. That would have
14 been produced at a ward level at a weekly summary for
15 their multidisciplinary team meetings for each patient. 16:27
16 MS. BERGIN: Okay. Chair, I'm just conscious of the
17 time, just to give an indication, we do still have a
18 way to go, I don't know that we'll be finished by five.
19 So I'm not sure if you want me to continue for as long
20 as we can and then stop? 16:27
21 CHAIRPERSON: No. I mean it has been a -- if we were
22 going to finish by five, I would seek assurances from
23 the stenographer.
24 MS. BERGIN: It could be just after five.
25 CHAIRPERSON: A barrister's 25 minutes is normally an 16:28
26 hour.
27 MS. BERGIN: Yes.
28 CHAIRPERSON: I think probably it is better draw
29 stumps. And I'm getting a nod from the stenographer.

1 She has had a particularly difficult day today.
2 MS. BERGIN: Yes. Certainly.
3 CHAIRPERSON: So I'm very sorry, but I am going to ask
4 you to come back tomorrow. I can give you this
5 assurance, you will be finished within an hour tomorrow 16:28
6 morning.
7 A. Okay.
8 CHAIRPERSON: And I can give everyone in the room the
9 assurance that I think we'll finish all the evidence by
10 lunch, quite comfortably. 16:28
11 MS. BERGIN: Yes.
12 CHAIRPERSON: All right. So we will draw stumps there.
13 Thank you very much. Can we see you back here, if you
14 could be back here by about ten to ten? Okay. We'll
15 stop there. Thank you. So, 10:00 o'clock. 16:28
16 MS. BERGIN: Chair, apologies. I wonder Chair whether,
17 hopefully I don't overstep, whether it might be
18 appropriate to give the usual indication to the witness
19 about being under oath in terms of the evidence.
20 CHAIRPERSON: Yes. No, you're quite right. These 16:29
21 aren't formal court proceedings, but it's best that you
22 don't speak to anybody about your evidence that you've
23 given or that you are about to give tomorrow.
24 A. Okay.
25 CHAIRPERSON: You've probably got better things to 16:29
26 think about.
27 A. Yes.
28
29

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1 CHAIRPERSON: Right. Thank you.
2
3 THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 27TH JUNE
4 2024 AT 10:00 A.M.
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