MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 5TH JUNE 2024 - DAY 88

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88

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INDEX

THE INQUIRY RESUMED AS FOLLOWS ON WEDNESDAY, 5TH JUNE 2024

CHAIRPERSON: Right, thank you. Mr. McEvoy?

MR. McEVOY: Morning, Chair, morning, Panel. The first witness today is H291. 09:52

CHAIRPERSON: And there's no application?

MR. McEVOY: No application.

CHAIRPERSON: Okay, let's get her out.

09:53

H291, HAVING BEEN SWORN, GAVE EVIDENCE TO THE INQUIRY AS FOLLOWS:

CHAIRPERSON: H291, can I just welcome you to the Inquiry. You're going to be referred to throughout as H291. If you make a slip and give your own name, don't panic about it, because we have a system whereby we can get it stopped and it won't be on the transcript. All right? 09:53

THE WITNESS: Thank you. 09:54

1 Q. MR. McEVOY: Good morning, H291.

A. Good morning.

2 Q. Before you is a folder with a statement in your name and under your cipher, dated 20th May this year. It's 17 pages in length. Are you content to adopt that statement as your evidence to the Inquiry? 09:54

A. Yeah.

3 Q. Well, what I intend to do is to summarise the thrust of the statement to the Inquiry, and then we'll stop at

appropriate junctures and there are some topics that we'll discuss, if that's okay?

A. (Witness Nods).

4 Q. By way of introduction then, you were a consultant clinical psychologist at Muckamore Abbey Hospital? 09:54

A. (Witness Nods).

5 Q. For the purposes of your statement, the period that you can speak about is between April 2015 and June 2021.

You then tell us about your educational background and 09:54
qualifications and attainments. You have a doctorate in clinical psychology. You then tell us about your employment background and roles and positions prior to working at Muckamore. You qualified as a clinical psychologist in June 2012. You had a community post 09:55
within the Belfast Trust, working with adults with a learning disability who displayed mild to moderate mental health presentations. In that time you may have come across individuals who were former patients of Muckamore Abbey Hospital but you can't recall, and you 09:55
weren't involved in the admission of patients to the hospital.

You then go on at paragraph 5 of your statement to tell us that in 2015, you applied for the role of Band 8A 09:55
specialist clinical psychologist based at Muckamore Abbey. You were successful in that application and you began working there, as you've indicated, in April 2015, working four days a week.

Having come from a community background, what was it that made you choose to go and work in Muckamore?

A. I think I had attended there at different times throughout my career. I'd been there recently in training, attending training programmes. I suppose it was I'd worked across a lot of sectors within the learning disability field and it was a new progression for me to work within the inpatient setting, really.

6 Q. Okay. As we go on, if you could lift your voice a little bit and try to speak slowly. 09:56

A. Okay.

7 Q. It's a little bit artificial and it's something we all lapse into from time to time, myself included, but if you can try to speak as slowly as possible. 09:56

A. Okay.

PROF. MURPHY: Can I just add to that before we go on? We've heard from a number of witnesses that they were aware really quite early on that Muckamore Abbey was going to be closing. Was that something you knew about when you joined it? 09:56

A. No, I don't believe that was the case then, no. I don't think so.

8 Q. And what was its reputation, the reputation of the hospital as you knew it at that time in April 2015? 09:57

A. Ehm, I suppose, yes, I mean, it was well known within the learning disability field, you know. It's something, working within that area for many years, I suppose different people had had, you know, experience

of being in there or being -- you know, come out again. So, I suppose it was just the reputation that it was an institution. It was so dominant, you know, within -- everybody sort of knew about it, I suppose, in the learning disability field. 09:57

I'd more recently been up in one of my jobs and had been taken for a tour around the new building in the new opening of the hospital ward. So I suppose I was thinking of it being, you know, progressed and 09:57
developed and new wards built and that it could be a good place to work.

9 Q. Okay. As you've indicated in your evidence to Prof. Murphy, you had no inkling about its closure or talk about its closure? 09:58

A. No, I don't think that was -- I mean, whether that was -- I'm trying to think back now actually but I don't recall that being something prominent at that time, no. I suppose it was always a move to reduce the numbers in the hospital because, you know, historically they had 09:58
held a lot of patients, and there was more of a focus on assessment and treatment and reducing the numbers. I don't recall it being about closing completely at that time.

PROF. MURPHY: So you felt it was a kind of front edge, 09:58
very forward looking type of place, did you?

10 Q. I remember coming from other mental health settings, maybe Knockbracken, for example, or other more institutional settings, and I thought this was more

advanced and there being development, you know, put into the hospital to try and promote the service, really.

PROF. MURPHY: Okay. Thanks.

11 Q. MR. McEVOY: In your statement you then go on to talk about your work with patients, a number of patients, directly with patients in Cranfield 1 and 2, the psychiatric intensive care unit, and Donegore, as it was known at the time. You then describe the induction process. As you say then at paragraph 7: 09:59

"On various occasions throughout my career when attending at Muckamore, I was struck by its size, its open space and how far away it was from the community. Historically, hospitals were built in rural areas, separate from community life." 09:59

Was that, as far as you were concerned and from your professional perspective, a good or a bad thing?

A. Well, I think it was a mixture. Obviously I don't think, I suppose, historically it wasn't great that these institutions were built so far away from local communities. I would certainly, you know, have been an advocate of de-institutionalisation. I know earlier in my career, having attended there for training programmes, I had seen other wards which were not new and modern but those ones, I think, had been closed by the time I started working there. 09:59 10:00

Sorry, have I answered that or...

12 Q. That's fine. Then you go on and describe how your role as a specialist clinical psychologist was a direct clinical role, and your training as a clinical psychologist ensured that you had core professional competencies to care for patients. You describe then your management; you were supervised by H258, and H258 was based on the site and was available to you on a frequent basis. You met for monthly supervision with H258. 10:00

You then go on at page 4, paragraph 9, to describe how you had access to patient records held on the wards. You spoke with ward staff who provided information on patients, and you attended multidisciplinary team meetings where it was discussed who was to work with which individual patients essentially. The multidisciplinary team included a consultant psychiatrist, ward nurse, behavioural therapist, occupational therapist, social worker, other allied health professionals, for example occupational therapy, speech and language therapy, and then any junior medic on placement. 10:01

You go on then to describe how patient care plans were discussed, which were held weekly and updated accordingly, usually by named nurses. You'd have discussed how a patient had been since the last meeting, and what was pertinent to share about the 10:01

individual regarding treatment progress or any risk issues. Patients could choose to speak to the team at the end of the meeting according to specific ward practices, and that would have depended on the patient's level of ability. 10:01

Was that something in terms of patients having the opportunity to speak to the team that would have happened frequently, in your recollection?

A. As I say, there different wards had slightly different practices, so I know one ward, for instance, would have regularly invited people in at the end of that weekly meeting. I mean, you would have been going onto the wards to speak to patients as well, but it was their opportunity to come in and speak with the MDT collectively, yeah. 10:02 10:02

13 Q. And was that a positive opportunity --

A. I mean, it was very much left to patient choice if they wished to come in, yeah. And it was trying to give them their opportunity to have their voice really and ask any questions that they might like, or just to tell you about their week, really. 10:02

14 Q. Okay. You then describe how family and community providers and involved professionals were invited to meet with the MDT during regular review meetings, and patient advocates were also invited to attend. In your recollection, did families often take up that opportunity? 10:02

A. Yes. I mean, there would have been regular, I think it

was three-monthly review meetings but, I mean, families could have come up in between times if they wished, you know, more regularly. They would have been for more longer stay patients. But I think it just depended. It wouldn't have been every family necessarily or, you know, even when things progressed, there would have been more resettlement meetings and things and families would have come up to those as well. But I suppose it just depended on the individual patient and the involvement of their family, and even ability to get there and stuff, you know, because it was quite a way away. Sometimes you would be in community and social -- hospital or community social workers might have helped get families to those meetings if they chose to, you know. It just varied really. 10:03

15 Q. Then you go on in the next paragraph to talk about how there were occasions where, within the MDT, there would have been differences of professional opinion. You give an example in relation to one patient who was due to leave Donegore and go on an offsite social activity on the following day. You recall how that patient had displayed an episode of challenging behaviour, and the result was that the opportunity to attend the activity was to be withdrawn as she was deemed a risk. At this meeting, then, you recall how you raised the concept of positive risk-taking as part of an evidence-based positive behavioural support framework to guide practice, and you suggested there may be a heightened degree of risk that the patient may display further 10:03 10:04 10:04

behaviours of concern if she presented as settled on the day of the activity and was to be informed that she couldn't go or couldn't attend.

You respectfully challenged this custom of not being able to leave the ward for an arbitrary period of time following an incident, and advocated that staff should dynamically assess the risk on the day of the planned activity. You believe that the patient attended the activity with support of ward and behaviour therapy staff. 10:04 10:05

Can you help the Inquiry understand whether it was common to prevent patients going on activities if they had been challenging? Was that a common practice? 10:05

A. I think it had possibly been a practice, you know. I suppose even prior to maybe me working there, just from what I had heard, you know, there was maybe -- I think it maybe might have been. Like, you know, a 12-hour or 24-hour period, you know, and that was deemed disposed in terms of risk. I suppose that was something I was trying to challenge at that time, that, well, you know, where's the evidence base or the rationale for that particular timeframe really, and what, you know -- really what we would be looking at if it was another day, it's a new day, it's a new start, you know, for that individual, it's better to assess what the risk might be on that day really. 10:05 10:05

16 Q. Was it formalised in care plans?

A. No, I don't think so. I don't know. I think it might have been more ward practices.

17 Q. Yes. Was it seen, whether by the patient themselves or indeed by staff and the hospital community, as a form of punishment? 10:06

A. I think it could be perceived that way, yes. So I suppose that was something I was trying to challenge respectfully. I mean, I think these types of customs and practices where people hadn't -- you know, they weren't thinking about -- you know, trying to make 10:06 people think that is how that could be perceived really, and it's not our position to punish. You know, I suppose I talk about having consequences to behaviour and my role was to try and bring a different narrative to that, really. 10:06

18 Q. Okay, thank you. In the next paragraph you talk about the process around meeting with patients and engaging with them. You would usually have spoken with a member of nursing staff to discuss the patients you were to meet and to enquire how they were generally and if you 10:07 needed to be aware of any issues. You would have introduced yourself to the patient, explained your role, asked the patient if they were willing to work with you. You say your role was to develop a psychological understanding of the patient's 10:07 presentations, known as formulation. It often included assessing risk factors -- I beg your pardon, factors, I'm sorry, such as life history, any experience of trauma, and factors that may predispose, trigger and

maintain difficulties, as well as identifying protective factors and personal strengths. You refer to the Hastings model being a model which provides a conceptual framework for understanding why challenging behaviours occur in people with developmental disabilities. 10:07

One point that you pick up on in this paragraph then is in relation to the role of the environment. You describe this as being crucial, both physical and interpersonally, physically and interpersonally in addressing and maintaining processes. You say that this informed support needs and intervention approaches. As you have indicated, you met with patients weekly, but you say there was no specific area in dealing with patients, and therefore securing appropriate space to carry out therapeutic intervention could be a challenge on the ward. You often used the day area or the visiting room to meet with patients, or you went for a walk around the grounds. 10:08 10:08

That absence of a specific area for carrying out your work, did that amount to any kind of -- did it impede your work in any way?

A. I think sometimes yes. You want to provide a therapeutic environment, and that can often mean a safe space. You want to create a safe space for somebody to engage with you, and sometimes then that wasn't always possible if you were on a side area of a ward, you 10:08

know; if maybe things were unsettled or just busy. You know, trying to give people privacy, I guess. That could be difficult.

There had been at one point, one of the earlier times of working there, there were rooms outside the wards within the ward buildings that I could have used. But then following, you know, the safeguarding allegations and the Inquiry, other members, multidisciplinary team members, were then moved into those offices to be closer and more based within the ward environment. So that's kind of then how I lost some of that space, if you like. So, at a time there had been more room to do that. 10:09 10:09

I mean, sometimes as well it might have been useful to, you know, if maybe -- if a client was maybe a bit more unsettled, it might have been useful to have other people around. You just wouldn't have known if you might have needed a bit of support or if they wanted to just get back to the ward. Sometimes we could have a positive, but other times I suppose it could impede things a bit. 10:09 10:09

19 Q. From what you have just told us, it seems then that when safeguarding allegations and other allegations came to light, there was a perceived need to bring other professionals closer to the ward environment? 10:10

A. Yeah. People were then more based. I think it was maybe social work teams or other members that were

maybe more based more widely across the site were then based within the ward settings.

20 Q. How was it then when that happened that if what you say is right - I am not doubting it - but if what you say is right that psychologists seem to lose out when that decision happened, when the decision-making around that was taken? 10:10

A. I think just even - and this happens even today in the community in different places that you work - but it seemed to be a medical or clinical environment, those other more different types of spaces aren't maybe thought about in the planning and design of environments, that what's going to be needed. For example, if you are in a hospital setting, it wouldn't be unfamiliar even in some community centres where you are trying to find a room and it's a very clinical room, there might be a sink or a bed, for example, in it. So I don't think that had been properly thought about, even at the design, that you would need maybe slightly different types of rooms. 10:10 10:11 10:11

There was the visiting rooms I suppose you could use that were for families coming up and visiting. They were probably more, you know, in mind of what you would be wanting, comfortable seating and privacy and that sort of thing. But yeah, I suppose just that sort of -- maybe that just lack of insight or forward planning about the different needs of the different members of the multidisciplinary team to do their work, 10:11

really.

21 Q. Okay. Then at paragraph 12 you describe how Muckamore was a hospital, obviously a hospital setting, treatment was largely influenced by a medical model. Was that the predominant model for treatment within the hospital? 10:11

A. Well, we were aware we did have psychologists and even, you know, behaviour nurse therapists would have been delivering psychological interventions. But I suppose it was just commenting on the fact at the end of the day it was a hospital setting. 10:12

22 Q. The fact of that influence, of the medical model, can you tell us about whether or not that informed approaches to the use of medication?

A. Well, yes. I mean, I suppose medical model, that is a core part of treatment then, you know, is medication. I guess you were endeavouring to have a holistic view of the client need and, you know, medication might have been one part of that. So I suppose other members of the multidisciplinary team were also trying to bring their contribution to that treatment as well. 10:12 10:12

23 Q. Do you feel able to offer a view in your professional experience of the hospital whether there was a tendency to over-rely on the use of medication?

A. I mean, I suppose there were probably... It was more likely people would be prescribed medication than not, I suppose. I mean, I know we would certainly have advocated for least restrictive measure, so trying to intervene with psychological approaches, for example, 10:12

before you maybe would get to the point of emergency PRN. But I think that with different models, then maybe some people would have gone to psychological approaches first, but if your training was medical, you might have gone to a medical approach as your first line. 10:13

CHAIRPERSON: Sorry, just so that I understand. When you say more likely than not that people would be prescribed medication, are you referring specifically to PRN or wider medication than that? 10:13

A. No, I suppose wider. A lot of people -- I suppose I'm just trying to recall. Most people, I'm sure, were prescribed something, you know, there in the hospital as part of their treatment.

CHAIRPERSON: When you referred to a medical model, would the contrast to that be a residential model? What do you mean by medical model? 10:14

A. I suppose, yes, maybe, you know, even in terms of very much diagnostically driven. Whereas, for instance, I'm coming from a psychological point of view so it's formulation driven, it's about looking at an individualised approach. I'm thinking about other variables, you know, so it's not always about a disease model per se or, you know, psychiatric disorders per se, it's about trying to bring in other ways of thinking to understand the people that we're working with. 10:14

PROF. MURPHY: I mean, in the NICE guidelines on challenging behaviour, it says that you shouldn't be

using medication on its own, it should always be allied with a psychological approach and that you should try the psychological approach before you do the medication. But was it really the other way around in MAH, would you say? 10:15

A. I suppose as people were coming into hospital maybe already on a regime of medication as well, so it probably wasn't common that you have had the opportunity to begin with psychological work. People maybe were already on medication and you were trying to 10:15 then complement that with psychological approaches as well.

PROF. MURPHY: Thank you.

MR. McEVOY: On page 6 then at paragraph 13, you describe the process around admission. When a patient 10:15 was admitted to a ward then, you tell us the MDT carried out an assessment. Primary treatment options included medical, psychological, including behavioural support, social, and a range of other multidisciplinary interventions. Details of medication were included in 10:16 the patient's treatment plan.

You weren't always involved in assessing patients admitted to wards and contributing to their care plan, as they may not have been identified as requiring 10:16 direct work with a psychologist. Part of your contribution to patient care may have been indirect, in other words through delivery of teaching for staff, facilitating ward team formulation sessions, or

providing consultation.

You go on and say then that you advocated patient choice in their psychological treatment, and aimed to promote a good quality of life. Behavioural support plans are an example of psychological intervention, and these included direct psychological input where indicated. 10:16

In terms of your statement that you advocated patient choice in their psychological treatment, was that approach for which you advocated well received by your colleagues? 10:16

A. I think, yes, it was. I mean, it might have been that we not always initially even considered that you would give somebody this, you know, for a psychologist, you know, people might have been able to see within a ward meeting that they could benefit from a particular approach, but that wasn't a given that they were going to want to engage in that at the end of the day. Obviously you have to offer choice and informed choice best as you can. 10:17 10:17

But no, I think, you know, it was received, yeah. You can't make somebody engage in something, there has to be choice there as well, and motivation and desire to want to engage in that. 10:17

24 Q. Okay. For the benefit of a lay person perhaps, can you give us an example, a practical example, of a

behavioural support plan, what it would have involved?

A. Yeah, okay. I suppose really in our Trust we would have focused very much on the use of a traffic light system. I mean, first of all you have your assessment information, so you're wanting to complete a functional assessment to try and understand the reason why a behaviour might be occurring for that individual. That would be summarised within the assessment part. Then also the plan. As I say, a traffic light system, you know, green, amber, red strategies that you try to help support that person to promote them having a good quality of life, really. The green will include lots of things that they really enjoy doing, and having good access to a meaningful activity throughout the day, for example; things that are important to those individuals to give them a good quality of life. Then maybe looking at -- so that's all trying to -- that proactive preventative aspect really, where you are trying to reduce the necessary -- the necessity for somebody that would need to engage in a challenging behaviour, because you are trying to make sure their needs are being met, really. 10:18 10:18 10:18

Then the amber might be where maybe somebody has become a bit more unsettled and you have some strategies. That might be when you start to move in and offer maybe a bit of a low arousal or space immediate to -- away from a busy environment. 10:18

25 Q. Sorry, a low arousal or what?

A. A low arousal space maybe or an approach, you know, if you have somebody getting a bit distressed with something.

Then the red ones are your reactive strategies which are sort of trying to avoid but they are there if you need them, really. You sort of use that as a last resort and you try to do the least restrictive as possible. 10:19

For some people, you know, a period of medication might have come within that amber or red bit. Does that answer it?

26 Q. Thank you.

PROF. MURPHY: Can I just ask you, given what we've heard from other witnesses about the difficulties of the environment - so, noise and the numbers of distressed patients and sometimes radical shortages of staff - did you feel those kind of behavioural support plans were realistic, were possible in such circumstances? 10:19

A. I think that totally taps into the part we mentioned earlier about the context and the environment is crucial, yes. So some of that is outside of your control, and that's where I think it's really important that you have the... So positive peer support is, you know, so much about an organisational framework and about the environment and the system, it's not just about the plan, because you can't work on just the 10:20

plan, you have to build in those wider systemic structures as well. I suppose that was a key challenge in the hospital, to be able to --

PROF. MURPHY: But you didn't think it was impossible to provide the kinds of things you describe in the green part of your traffic light system? 10:20

A. Do I think it was possible or impossible, did you say, sorry?

PROF. MURPHY: Did you think it was possible to provide what was in the green zone, you know, the extra activities, the extra support, going out for walks, all that stuff? 10:20

A. There could be challenges to it. Certainly when there were staff shortages, yes, it was difficult. I know in the team then I worked in, behavioural nurse therapists would have gone in to try and do that work directly too and support the wards, and the behavioural assistants that we employed as well to try and support that work. But certainly, yes, you know, it could be challenging to implement that, particularly if somebody had planned to go out for a meal somewhere maybe in the community and you didn't have the staff to be able to accompany them. That was a real challenge, yeah. 10:21 10:21

DR. MAXWELL: Can I ask, recognising the whole structural element - and we have heard a lot about staff shortages, some very significant; sometimes they were down to just one or two registered nurses - did the behaviour support plan have a contingency? Because it's all very well writing a plan for ideal 10:21

circumstances, was there also a "and if you can't do this, if you really can't do this, here is plan B", or was it ideal plan or nothing?

A. I think it was more about if you couldn't do, for example, one thing that was in there, you would try to do something different. You know, I don't think we had written it in as a contingency per se. I think you were trying to get across the culture of how you would still continue to support somebody well. 10:22

DR. MAXWELL: If there had been a behaviour support plan for a patient and this patient had become very distressed, it was overcrowded, there were other patients who were very noisy and there were recognised staff shortages, would you, as a psychologist, have completed a Datix form to say this was an adverse incident where they weren't able to follow the plan? 10:22

A. Ehm, that's a good question. I can't recall. I haven't done that.

DR. MAXWELL: I'm not sitting in judgment, I'm just wondering whether that was something would have been expected of you, or whether data wasn't actually collected on why it wasn't possible to implement. Because we've heard a lot about these things weren't done, and I'm just asking was it ever discussed that data should be collected on why it wasn't done? 10:22 10:23

A. Yeah...

DR. MAXWELL: If it wasn't, that's fine. I think that's probably quite normal not to.

A. I see your point, definitely, yeah.

CHAIRPERSON: Can I just ask on positive behaviour support plans. Presumably for a support plan to work, the staff have to be engaged; the nurses and the care staff have to be engaged?

A. Mm-hmm. 10:23

CHAIRPERSON: I just want to understand how it actually works. You see a patient maybe, what, once a week?

A. I mean, depending on the input but our behaviour therapists, for instance, would have been daily in the wards, you know, working daily with clients, trying to 10:23 implement something. Then practice leadership was a really big part of that, so you were trying to support the staff through practice leadership.

DR. MAXWELL: What is a behavioural therapist?

CHAIRPERSON: Yes, quite. 10:24

A. So, they are usually nursing background in the wards and they sort of train to do more behavioural approaches, really that being one of their... Although it's everybody's kind of role, there's different levels of the system, but I suppose that being their kind of 10:24 key focus, really.

CHAIRPERSON: And would there have been a behavioural therapist on every ward?

THE WITNESS: Yes. Yeah.

CHAIRPERSON: We have also heard about named nurses for 10:24 patients.

A. Yes.

CHAIRPERSON: Would the named nurse be aware of a positive behaviour support plan, and would they discuss

it with the writer of the plan?

A. Yeah. I mean, they would have had involved in devising and developing where possible because, you know, you want to have people who are supporting that individual involved to help you complete the assessment to begin with, and then to help develop that and to be able to implement it.

CHAIRPERSON: So when they are developed, does that mean that you would sit down with a named nurse and say, well, look, this is what I think we should be doing and the named nurse will give you feedback? How does it work?

A. Yeah. That would have often been discussed at like a multidisciplinary meeting, and then there was a section at the end for people to sign off that they had been part of that meeting, that they had agreed to what was in it.

CHAIRPERSON: Okay. Thank you.

A. Or if they had wanted to make suggestions or whatever.

CHAIRPERSON: Okay. Thank you.

27 Q. MR. McEVOY: So, staying with the topic of the positive behaviour support and indeed its use among the staff, thinking particularly about education around PBS, this is something you pick up at paragraph 18 on page 8, positive behaviour support. You touched on practice leadership a few moments ago but here you say:

"Through practice leadership, behavioural therapists supported staff and patients to implement therapeutic

treatments detailed within positive behaviour support plans. There was an ongoing need to share an enhanced knowledge and skills of positive behaviour support as a framework."

10:26

As part of this, then you describe how you were part of designing and delivering positive behaviour support teaching in sessions with staff on the wards. You worked with senior management in the hospital to promote positive behaviour support training but you recall that due to low staff numbers on wards, it was a challenge for staff to attend training. You shared knowledge of ongoing peer learning and support platforms available, and go on to describe a bit more about that.

10:26

Thinking in particular about the question posed by low staff numbers on the wards and the challenge that that raised, how did you square that circle of staff in terms of them having pressures and other demands on their time, they couldn't get the teaching time or learning time, effectively; protected time I think sometimes it's called. How were you able to convey the message and the importance of the concepts around positive behavioural support?

10:26

10:27

A. Yeah, I think that was an ongoing challenge really, and I think it's the case of lots of environments. So I suppose trying to embed training is one part of it really, but you are trying to embed a culture as well.

That would have been then trying to engage, you know, with staff at ward level; with management staff, you know, at an organisational level. So you are trying to embed this as a culture that's, you know, infiltrated through policies and practices really rather than one-off. Teaching has its place obviously but it needs to be more than that as well.

You know, we just did as best as we could to try and support people attending where they could. The ward managers would have tried to work with us on that and release people but it was, you know -- there was an ongoing challenge around that, really.

28 Q. I appreciate you might not have an idea of numbers but in terms of the proportion of staff, would you say that more were able to get the teaching than weren't, or was it the other way around? Can you help us with that?

A. At different time points. We did the training at different time points and it could vary. I think... I remember around 2018 sort of doing it, and a good proportion of staff I crossed out were able to attend then. I suppose more recent before I left, it was trying to implement it again and at that point staffing issues were very pertinent.

I don't think we could say everybody was trained, you know. It was just it was trying to deliver what we could, really.

PROF. MURPHY: So by the time you left, which was, I

think, 2021, were there very large numbers of agency staff working?

A. Yeah.

PROF. MURPHY: Because presumably they were the ones that it was really difficult to provide training for because there might be a different person tomorrow from today et cetera? 10:29

A. Yeah, yeah. There was a high turnover, yeah. That was a challenge as well.

PROF. MURPHY: Is it right to say that Cranfield wards and PICU, where you were mainly working, weren't protected from that? In other words, they were just as likely to have agency staff as any other ward? 10:29

A. Yeah. I mean, I think at those times I was working in that ward, there maybe wouldn't have been quite as many agency staff. But yes, any ward, I suppose, could have had agency staff, yeah. 10:29

29 Q. MR. McEVOY: In the following paragraphs then, you go on to talk about the situation pharmacy within the hospital, and we touched on the question of medication already. You then talk about your promotion, at paragraph 20, to the post of consultant clinical psychologist. At paragraph 18 then, towards the bottom of that paragraph you say that in your role as consultant, you continued to work directly with patients; you carried a smaller case load than in your role as a specialist clinical psychologist because your new role had a greater focus on service development and strategic leadership. Strategic focus included working 10:30 10:30

psychologically at the client team service and organisational level. During this time, you were involved in increasing the number of behaviour support therapists - which I think is something you have already told us - and introducing behavioural support assistance within the hospital who supported staff working on wards to implement therapeutic interventions. 10:30

You then go on to talk about supporting the strategic implementation of positive behaviour support. You describe how it's focused on embedding things as an organisational framework rather than solely focusing on the individual personal level. Indeed, that's something you've mentioned a few moments ago. 10:31

Moving on, though, to paragraph 22 then, you talk about how, when you were a specialist psychologist, you would have seen Datix incident reports, records, as part of your direct work with clients or within the MDT meetings. When you became a consultant clinical psychologist, you attended weekly clinical governance meetings with senior managers and ward lead nurses where CITREP reports were shared and reviewed and the team was made aware how incidents occurred and if anyone was seriously hurt. You recall that data was collated by staff in a governance role. 10:31 10:31

Thinking back to those weekly governance meetings, were

trends in the numbers of incidents considered or were you just focusing on individual patient incidents?

A. I'm trying to recall was it... I think it was more so on the individual incidents.

30 Q. Therefore when you say that data was collated by staff in a governance role, do you know what the purpose of that data collation was then? 10:32

A. I suppose it was to give us information in relation to incidents that were occurring; trying to focus on staff and patient wellbeing; trying to reduce those. Yeah. 10:32

31 Q. Okay. In the following paragraphs then, you tell us that you didn't witness any safeguarding issues between staff and patients during your time at the hospital. You do recall having concerns reported to you, and you describe some of those. You remember a behavioural assistant raising a concern about agency staff and how they approached and interacted with a patient involving their personal care. The assistant raised her concerns with the senior nurse on the ward at the time, per Trust policy. You weren't required to take the report forward as the policy required the member of staff in the first instance to report to the nurse in charge, but it was something that was raised with you, and that person obviously felt that you were an appropriate person to raise it with then? 10:33 10:33

A. So I suppose, yes, that particular position, they would have been based on the wards largely and so it happened when they were on the wards so they took it -- but obviously when they came back over, you know, to the

office, they were talking about it and did share it with me.

32 Q. Okay. Then at paragraph 24 you describe being involved in an investigation regarding P116, who was on Cranfield 1 and Cranfield 2. The family had raised a complaint about the care provided to him on Cranfield 1, in relation to his physical care needs in particular. After the concern was raised, an independent was carried out by an individual, who the Inquiry has called H905. You were involved in the process from a psychological point of view and you were asked to comment on positive behavioural support and formulation and psychological aspects of his care. You don't know of the outcome, though. 10:34 10:34

Do you know why the outcome wasn't shared with you?

A. I am not sure but it maybe just had still been in process, as such, possibly.

33 Q. Okay.

A. I mean, there was learning from it, I suppose. I don't know the outcome in terms of what -- I suppose there was shared learning part of that, me meeting with that person was how we could learn from it, certainly. 10:35

34 Q. Yeah.

A. So, for example, making sure we were incorporating physical health into our psychological formulations, for instance. But I don't know the specific outcome of that, if that makes sense. 10:35

35 Q. Yes, I suppose that is where I was going.

A. Yes. Sorry.

36 Q. No, no. Was it an opportunity within learning to be shared.

A. Yes. I know my colleague, the behaviour support nurse as well involved in that, you know, we both found it a very useful process. Obviously it was learning for us as well. 10:35

37 Q. Yes. At paragraph 25 you deal with your clinical awareness around the use of seclusion, sedation and physical intervention. You recall that you would be told by staff on the ward if that was used. You give an example of an instance where you were working with a young man who had left the site and, as part of the process, physical intervention was used. You were part of the staff to encourage him back to the hospital. Police were called to help staff bring him back. He was brought to the seclusion room in PICU to help him de-escalate. You and the other staff remained in the room with him. In an attempt to reduce the necessity of these interventions, you worked with ward staff and directly with the individual to support the de-escalation of patients to reduce the necessity of these interventions. 10:35 10:36 10:36

Thinking back to that particular instance, can you recall whether the approach that you adopted had resulted in a positive outcome, in other words whether or not the patient was less likely to repeat that behaviour? 10:36

A. I mean, I think it was more we were trying to manage the situation at that time for him. I don't know if it was as simple as that, that he would just not repeat it again, if that makes sense, because there are so many other factors.

38 Q. Of course.

A. But I suppose what I was talking about there was, yeah, just trying to be part of that, to try and help. I mean, we brought him to that, the room that would have been used for [inaudible], but we were -- me and other members of staff were still present with him at the time, trying to support him. Unfortunately, I think in that incident we did need to withdraw for a period and then, you know, he was on his own in the room. But ultimately we would work quite a lengthy time with him to try and prevent that.

39 Q. You then describe in the following paragraphs your recollections of the various atmospheres, your impressions of the atmosphere certainly on the wards that you worked on. You talk about, at 27, Cranfield 1 and 2. You say it was positive. You describe two members of staff having patient-centred attitudes and a good rapport with patients. You also positively recollect the ward manager in Cranfield 2, who you described as warm and welcoming and focused on the psychological care of patients and she spoke to you about psychological support needing interventions.

You do say then that staff shortages were common but

from 2017 and during the height of the investigations and staff suspensions, shortages increased, which affected staff morale. Shortages meant staff were often deployed across wards within the hospital to help provide support where needed. 10:38

In terms of that, the effect on staff morale, how do you think that affected your work as a psychologist and as a specialist psychologist within the hospital, and the service that you were trying to provide? 10:38

A. I mean, I suppose the wellbeing of the team is also something that a psychologist is concerned about, you know, within their work. If this team isn't -- you know, if the morale is low and -- you know, as we talked about earlier there, the support of staff is so 10:39 important, so staff then can support our patients, effectively. So they are definitely linked, obviously.

CHAIRPERSON: Did you become aware when you were seeing patients that that was directly affecting patients' behaviour and their treatment? 10:39

A. The low staff morale?

CHAIRPERSON: Yes.

A. Not in specific that I can recall but I'm sure it did have an impact. You know, people not being maybe just as available, or just that sense of low morale on the 10:39 wards.

CHAIRPERSON: Not just the morale but the staff shortages which you were talking about earlier, did they affect patient behaviour?

A. I would say yes. I mean, I think I've mentioned it in the statement about just the psychological impact of that, about people not being around, not being available. People who were familiar and consistent people in a patient's life maybe not there any more, or not as available to them, having to be called into other wards; them being maybe supported by agency staff who were less familiar. All of that would lead to reduced psychological safety, really. So I think it had impacted our clients and would have been a contributory factor maybe for some behavioural challenges, yeah. 10:40 10:40

CHAIRPERSON: Going right back to what you were saying earlier about positive behavioural support plans, would those include things like patients going on outings or patients going out of MAH, or is that not really what a behaviour support plan focuses on? 10:40

A. Sorry, what did you say? Would it focus on patients getting out?

CHAIRPERSON: Getting out into the community or getting out on a bus, or would that be -- 10:40

A. Absolutely, yeah. That would have -- a lot of that would have been in what we call the green, where you are trying to promote a good quality of life. So that would have all been incorporated in that aspect, yeah. 10:40

CHAIRPERSON: Presumably if there are staff shortages, that opportunity diminishes?

A. Yeah. I mean, we would have supported patients. If maybe they weren't able to get off site, supported them

in trying to do something else enjoyable, you know. But yes, so the transport even could have been an issue; maybe we didn't have a driver, for example. Then in later times, we got some of our behaviour assistants trained to be able to drive the bus on-site to try and increase that option for people. Or depending on peoples' support needs, whether they needed two-to-one staff. So there was all of that factors as well. It could have been impacted it, yeah.

CHAIRPERSON: Thank you. 10:41

40 Q. MR. McEVOY: At 28 and 29 then, the two following paragraphs, you describe how you moved over from Cranfield to PICU in 2018. In 29 you talk about how you worked on PICU after the allegations of abuse were made. You say that you believe the allegations against staff and the suspensions had an impact on patients in PICU and across the hospital site, and you were mindful from the patients' perspective that core familiar people in their lives disappeared. In your opinion, this was difficult for patients who had previously experienced abandonment, an experience which was potentially repeated and re-triggered when staff are no longer there. From a psychological point of view, you say you believe patients needed a narrative to help them understand what was happening. That was something that was important for all verbal and non-verbal patients. 10:41 10:42 10:42

As it was difficult, you say, to maintain staffing

levels with the PICU, it was decided that it should close in and around the end of 2019 and patients were then to be amalgamated into other wards during this time.

10:42

So picking up on what the Chair asked you a moment or two ago, thinking about this effect on PICU in particular, that is the effect of suspensions and disappearing staff, was any effort made to explain to patients what was going on and why staff were disappearing? I know you talk about a narrative but how does that translate into sort of -- you know, from the lay person's perspective, how is that conveyed?

10:42

A. Yeah, I think there were -- I won't take credit, it wasn't me leading on it necessarily, but presumably like the TILII group, I think, had done some work with client groups as well just to try and devise a bit of a narrative. Because I suppose patients were aware, there was things on the news, and it was to try and help alleviate, you know, any fears and reassure patients what was happening as best we could. So there was work that would have been done and completed. I can't totally recall the specifics; I wasn't directly involved within that specific project.

10:43

10:43

But when I talked about the narratives as well, I was mentioning about times when patients were admitted and, you know, maybe not even understanding why they were in hospital; it was really important to have that for

people.

41 Q. Then you talk about how, after PICU was closed, at paragraph 30, you moved across to Donegore - now known as Ardmore - in early 2019. This was a female ward initially for assessment. There were some discharged placements often due to placement breakdown. Some premises for identified placements were being built and that had delayed discharge. That ward was then closed. You worked well with the manager of that ward, who was H285. Patients on the ward had complex care needs, and issues associated with patient compatibility were evident. 10:44 10:44

I suppose, in plain terms, is that another way of saying that patients weren't getting on very well together, or is that -- 10:44

A. Yes. I mean, I think there were some serious issues around that for us to try and support patients with, yeah.

42 Q. And it led then to a disturbed and distressed ward environment at times. There was a high turnover of staff; there was a high use of agency staff which impacted familiarity and consistency for patients? 10:44

A. (Witness Nods).

43 Q. Then you talk about how, in around 2018 or 2019, the head of clinical psychology within the Trust arranged for a reflective practice group from sessions across various wards in the hospital, and your psychology colleague H258 and you worked to support establishing 10:45

delivery of those groups alongside an external facilitator. Was that practice group a success on balance?

A. No, it was difficult. I think, you know, some wards seemed to make more use of it than others but it never got as established as we would have liked it to have got, really. I think it was difficult for staff at that time. You know, morale was very low, people were feeling very under scrutiny, not maybe feeling psychologically safe to be able to come. You need to be able to come and establish psychological safety to be able to take part in a group like that, I guess. Whether that was part of the reason, maybe, or it was just very new to people. I know reflective practice can mean different things to different professions, and that particular style maybe was quite new to people and they maybe chose not to engage with it. 10:45 10:46 10:46

44 Q. In the following paragraphs then on page 14, you talk about your continued drive to develop an organisational positive behavioural support framework within the hospital, and this meant meeting with senior nurses and service managers with whom you had good relationships. You recollect there was a growing recognition by senior staff that everyone was responsible for providing this support. Senior staff were supportive for staff to attend training but, as we discussed earlier in your evidence, this was a challenge due to staff shortages. 10:46 10:46

In the following paragraph then you talk about how

throughout your employment in the hospital, you worked with allied health professionals. When you arrived on wards, you linked in with staff to get their views on patient presentation and care. You worked with occupational therapists, behavioural therapists and speech and language therapists. You consulted and liaised with each other to care for patients to ensure you weren't duplicating services. For example, you worked with speech and language therapists to teach patients emotional literacy and how to display their emotions in an adaptive way. 10:47 10:47

You then talk about, in paragraph 34, your awareness that some staff in the hospital were related. You recall that there were a number of staff placed on protection plans. You worked with H906, who was a nurse in Cranfield 1. Her sister was also a nurse who worked in the hospital. H906, you recall, was placed on a supervisory and protection plan arising from safeguarding concerns, and you acted as you acted as H906's line manager. You weren't made aware of the specific details of the alleged safeguarding concerns or why she was placed on the plans, only the themes highlighted as part of her learning and training needs. She was required to provide a reflective piece on her learning as a result of training. You worked closely with the divisional nurse lead, H315, during that time. 10:47 10:48 10:48

Now, I suppose focusing on why it was that you weren't

made aware of the specific details of the alleged safeguarding concerns, I suppose a neutral well-informed observer listening to that might wonder how you would be able and best placed to help staff after safeguarding concerns in a supervisory role if you didn't know what the safeguarding issue was. Do you have any comment about that?

A. I think it could be difficult in practice. I think that's why then it was more about my role as trying to focus on the themes of how to support that person in developing maybe areas that had been highlighted that they needed to develop. But... 10:49

45 Q. I guess did you feel you were impeded in doing that if you didn't know what the safeguarding concern was?

A. It was difficult, yeah. 10:49

46 Q. Was it explained to you why you couldn't be made aware or weren't being made aware of what it was?

A. I think it was because it was an open investigation, really. I think it was -- I think there was limitations on who was to be made aware of the specific details. 10:49

PROF. MURPHY: So was the staff member aware of the reason for it, or was it just that you weren't allowed to know?

A. Do you know, I'm trying to recall specifically. You know, often staff maybe were -- they would have been called maybe to a meeting by HR and I might have gone with one or two staff to support them through that process. You know, in terms of specifically viewing 10:50

footage or anything like that, I don't believe they would have been aware of the exact nature of it.

PROF. MURPHY: In your view, would that have made it psychologically more difficult for them to work in MAH?

A. Sorry? 10:50

PROF. MURPHY: Would not knowing --

A. Absolutely. Very difficult.

PROF. MURPHY: -- have made it more difficult for them to work?

A. Yeah, yeah. I think so, definitely. And also just to protect the protracted nature of it. You know, when is this going to end? And I know towards the end when I was working there, there was more a move to be able to step people down, as it was called, off of those plans. But yes, it was a very protracted, long nature for people to be left dealing with that, yeah. 10:50 10:51

CHAIRPERSON: Can you give me, as a lay person - we don't need to discuss that particular case - but what a protection plan might look like?

A. So I suppose it was called like a supervision and protection plan. There might have been different themes maybe relating to what had been highlighted. So it might have been around use of MAPA techniques, or it might have been around adequate record keeping, for example. 10:51 10:51

CHAIRPERSON: So, just to take those two examples, might an individual be told not to use MAPA techniques themselves, or need to do so while being observed by somebody else?

A. Well, for some of them. For instance, some of the people I would have been working with on those plans who were being asked to do nonclinical duties, so some of them may not even have been -- may have been asked not to engage, not to be on wards, not to engage with patients. That in itself was very difficult because we were working in a clinical environment. How do you define what nonclinical duties were, really, especially when you didn't know what the issue was? 10:52

CHAIRPERSON: No, quite. Around note-making, which you mentioned -- 10:52

A. Pardon? Sorry?

CHAIRPERSON: I think you mentioned record keeping.

A. Yes. So there would have been maybe key learning needs highlighted as part of that plan, so maybe staff would have repeated specific training on records keeping; as I mentioned, maybe doing some reflective pieces where they had learned on those sort of things. 10:52

CHAIRPERSON: Then would that involve something having a look at or auditing those individual's notes? 10:52

A. Yes. We would have gathered like a -- each of those staff members, they would have had file, a supervision protection file. We would have demonstrated those learning outcomes and shared them with the divisional nurse lead. 10:53

CHAIRPERSON: So that sort of protection plan might actually be quite short? I mean, if that was what was required, if the issue was, for instance, record keeping, there is no reason presumably why that

couldn't be accomplished in a few weeks?
A. Yeah.
CHAIRPERSON: How long did they tend to go on for?
A. I think, I suppose, the incident I am talking about now, you know, initially it might have been so people weren't -- it is almost like this... I suppose it's because it was over such a protracted sense of time, people might have been identified that the protection plan wasn't that they didn't work with clients, for example. And then more as time went on, there was development of those plans, about what needs to take place so people can be stood down and demonstrate that they have, you know, adequately developed skills to prevent it happening again. So that was maybe more a movement towards the like of what we were talking about, where those themes then would be enacted and demonstrated learning, so then that somebody could be sort of stepped down from that. But it did take a while to get to that. 10:53 10:53 10:53
CHAIRPERSON: And what does "a while" mean? 10:54
A. Initially it was sort of people were placed on those protection plans, you know, and then over time I think the divisional nurse team developed the process, you know, to kind of how that would be evolved.
CHAIRPERSON: As a lay person, I'm just trying to get a sense of how long these things can go on for. Are we talking about weeks, months or years? 10:54
A. Months. Months into years, yeah.
CHAIRPERSON: Months into years?

A. Well, not into years but up to a year. You know, I had a staff member who was not in the workplace for six, seven, eight months, I'm sure.

CHAIRPERSON: Right. Thank you.

47 Q. MR. McEVOY: Towards the end of your statement then, H291, you say that you witnessed good care being provided by staff to patients on wards. That is the top of page 15. Staff went above and beyond, and you recall a patient who was afraid to attend a dental appointment. You can't recall exactly but you think the patient was on either Cranfield 1 or 2. Staff were compassionate and empathetic. If the patient became distressed, the staff helped them get back to a stable state and continued to worked well with them. You didn't witness poor care or abuse, and if you had you would have reported it. You then go on to describe how you became aware of the allegations of abuse when you were called to a meeting with other lead staff and ward managers by the manager of the hospital. You were shocked and in disbelief and you were devastated. 10:54 10:55 10:55 10:55

At paragraph 37 then, you say that the management of learning disability patients has changed over the years as there is a broader view and understanding of learning disability. You say that historically treatment in early days was based on the behaviour of the patient employing behavioural approaches. A positive behaviour support approach brings a more holistic approach, which you have described earlier in 10:55

your evidence, to the support of people with a learning disability. It combines behavioural analysis techniques with a strong ethics and value base, delivered in a person-centred way to meet the needs of individuals who present with behaviours of concern. 10:56

I suppose just finally then, H291, do you feel that that ethos was reflected in the way things were done in the care of patients at Muckamore?

A. I think, yes, we were certainly working towards that. 10:56
I don't think it had fully, been fully embedded. I think there was still a way to go with that, and I think it was moving. I think, you know, even from when I first started working there, for example, I think there would have been more -- the behaviour nurse 10:56
therapists, for instance, would have sat under nursing line management, and I think it was more deemed -- it was certainly much that was the role of behaviour nurse therapists, whereas hopefully over the next lot of years we have been working at developing more of a 10:57
culture, well, actually everybody has got a role in this and this is an organisational system approach. But that was still being embedded, you know. That was still -- we were still working on that, really.

MR. McEVOY: Those are my questions. The Panel may 10:57
have some more. Thank you very much.

QUESTIONS BY THE INQUIRY PANEL

PROF. MURPHY: Thank you for explaining all of that. I did have a question about psychologists in other parts of MAH, if I may? 10:57

A. Mm-hmm.

48 Q. You went there in 2015. Roughly how many patients would have been there at the time? How many wards?

A. Wards? Six or seven, I think it was, at that time.

49 Q. So you were specifically on Cranfield and PICU for most of your time? 10:57

A. No, I was mostly on Cranfield 1 and 2 to begin with. Then I would have spent the shortest time probably on PICU, I mean from the summer up until the winter when it closed. Then in the female wards the rest of my time. 10:58

50 Q. So can you give us a feel for how many psychologists were around on other wards? Like, did every ward have its own psychologist or were they very thinly spread on the other wards? 10:58

A. Well, I suppose the forensic wards, I wasn't directly involved working in those wards. So there was two, at least three, maybe four forensic psychologists around. Some other clinical psychologists had kind of, you know, come and gone, so at one point there were two or three of us. So we wouldn't maybe -- we would have tried to allocate ourselves to different wards and made sure we attended the ward rounds for those wards, if that makes sense. I would have had an assistant -- 10:58

51 Q. So each psychologist might have been allocated two or three wards, for example?

A. Possibly, yes.

52 Q. Is that the sort of --

A. Yeah. 10:58

53 Q. Thank you.

A. Two rather than three probably, yeah.

CHAIRPERSON: Presumably when you had your short time on PICU, you would have been working with forensic psychologists? 10:59

A. (Witness Nods).

54 Q. Again just for me as a lay person, is that an entirely different training or is that a subspecialty of psychology?

A. It's a different training path. It would have been -- it wouldn't have been in PICU necessarily, it would have been the other forensic wards that they would have been mostly working in. So yes, I trained in clinical psychology, and forensic psychology is a different training course. 10:59 10:59

55 Q. Could there be occasions when patients were transferred between from having been a forensic patient, as it were, potentially under the justice system, to a nonforensic patient?

A. Not that I recall, no. 10:59

CHAIRPERSON: Nothing from Dr. Maxwell.

Can I thank you very much for coming along to assist the Inquiry. We've asked quite a lot of questions as

we've gone along. Your evidence has been useful and informative, so thank you for giving up your time.

THE WITNESS: Thank you.

CHAIRPERSON: I think the next witness is due for 1:30, but might be here early? I'm sorry, 11:30. Okay, we'll start at 11:30. Thank you. 11:00

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS

CHAIRPERSON: Thank you. 11:23

MS. BRIGGS: Morning, Panel. We're now dealing with the evidence of witness H330; the reference is 262. There are no applications, Panel. If nothing further arises, we'll bring the witness in.

CHAIRPERSON: Fine. Let's get the witness in. 11:23

H330, HAVING BEEN SWORN, GAVE EVIDENCE TO THE INQUIRY AS FOLLOWS:

CHAIRPERSON: Good morning, H330, as I'm going to call you. 11:24

THE WITNESS: Good morning.

CHAIRPERSON: Don't get in a fuss if you mention your or anybody else's name because we have a system whereby we can stop it from going public and we can change the transcript. Almost every witness - almost every witness - has done it, so don't worry if that happens to you. 11:24

It's always a bit nerve-wracking when you start, but I can assure you in about three or four minutes you will settle into giving your evidence quite naturally. I'll hand you over to Ms. Briggs.

56 Q. MS. BRIGGS: Thank you, Chair. 11:25

H330, you know my name is Ms. Briggs; we've met just now. The first question is very easy. You have a copy of your statement in front of you in that folder; it's dated 22nd May 2024 and it runs to 39 pages. I want to 11:25 ask you, first of all, do you wish to adopt the contents of that statement as your evidence to the Inquiry?

A. Yeah, I do.

57 Q. I've explained to you already that I am going to spend 11:25 a good bit of time on the earlier parts of your statement, and use that to go around the various wards that you worked on while you were at Muckamore. Then, I am going to take a shorter look at some of the themes which arise later on in your statement. I'm not going 11:25 to go to all of them. I have told you that the Panel and the Core Participants, they have the whole statement, but there are one or two themes in there that I will touch on. Okay? 11:25

At the beginning of your statement then, you give the reader an overview of your work at Muckamore. You worked there from 2003 after you graduated from nursing at Queen's?

A. Yeah.
58 Q. You worked there until 2021; isn't that right?
A. Yes, I think so.
59 Q. Yes. Okay.
A. I think so. 11:26
60 Q. And you --
A. I definitely started in 2003.
61 Q. You worked as a staff nurse right up to a Band 7 ward manager; isn't that right?
A. Yeah. 11:26
62 Q. Okay. I want to ask you a little bit about the nursing diploma you did in Queen's in the early 2000s, okay? The Inquiry have heard some evidence, quite a significant amount of evidence about nursing education, and that's an area that's within the Inquiry's terms of 11:26 reference, okay, the topic of training. I want to ask do you think your preregistration education adequately prepared you for working at Muckamore?
A. If I'm honest, it was a long time ago and I can't clearly remember what all I learned at university, but 11:26 nothing compares to actual experience. Educationally, you can learn so much. I don't -- I don't really remember.
DR. MAXWELL: Can I subdivide that? So, when you train as a preregistration RNLD, it's for all areas of 11:27 learning disability; perhaps it's working for people in their own homes, working for people in community placements. Patients at Muckamore Abbey had quite complex needs. Sometimes in other fields of nursing if

you're going to work in a highly specialised area, you would do a post registration training to do that. So I suppose the question is you came out as a newly qualified RNLD and that would have equipped you to deal with quite a lot of the patients. Were the needs of 11:27
patients at Muckamore Abbey more complex than the training provided you with the skills to...

A. Yes, I would say they were. Every ward within Muckamore Abbey was very different. So once you were allocated to your ward, that gave you a very good idea 11:28
of the type of needs then that you were going to be working with and the things that you would need further education on. My first ward was Rathmullan where we never learned about peg tubes and catheters and all those things in university because they're so specific. 11:28
Really, it took you to get to a ward to identify the needs of those patients before you could sort of get training on those.

DR. MAXWELL: So you had to pick up the skills for that on the job? 11:28

A. Yeah. Yeah.

DR. MAXWELL: Thank you.

63 Q. MS. BRIGGS: What about things like being taught at Queen's about reporting safeguarding issues and reporting fitness to practice concerns and the likes of 11:28
whistle-blowing; do you feel, looking back, that you were adequately taught about those?

A. You were taught, absolutely, that these things were important, that there were policies in place. You knew

what the hospital policies were and they were always easily accessible, the information was always there. I suppose the sort of thing, like whistle-blowing, it's until you need it that you would really be that familiar with it. You knew it was there, you knew you could do it. The university, I do believe, made you aware of all these things.

64 Q. What about the likes of restraint or the use of MAPA, how adequate or not would you say that your Queen's degree was in teaching you about those things? 11:29

A. I don't recall much about what I learned at my Queen's degree, it was quite a few years ago. You got that training in Muckamore once you started. At the time when I started, you only got the training if you worked with people who would have required -- had those needs. 11:29 So, within my time in Rathmullan, I would never have had any training in that, although over the years it did become that all staff were trained in it. I can't remember what year that would have happened.

11:30

But no, until -- definitely university didn't teach you restraint. They would have taught you personal safety techniques, which was one-day training.

65 Q. Thank you very much. You've said already in your evidence, and you say in your statement, that you 11:30 initially you went to Rathmullan; that was 2003. Then at paragraph 7 of your statement you say that you were involved to the Ennis Ward about two years later, in 2006, when you were promoted to an E grade staff nurse?

A. (Witness Nods).

66 Q. You say there at paragraph 7 that Ennis was a female ward for patients who were awaiting community placements, what we would now call delayed discharge. You say you don't recall this terminology often being used at the time. About halfway down paragraph 7, you say: 11:30

"The patients in Ennis would have been in the hospital for many years previously and most would have remained in the ward for a further few years following my time there. The delay in discharge", you say, "was finding suitable community placements, and once placements were identified, there was no hold-up with discharge planning and processes being carried out." 11:31 11:31

Is it fair to say, then, that most of the patients on Ennis Ward were there for a significant period of time, that is to say years?

A. Yeah. 11:31

67 Q. Rather than months or weeks?

A. Yeah. Absolutely.

68 Q. Can you say, looking back, how often patients were there on average waiting for community placements?

A. I can't recall from Ennis an average timescale but it was definitely a significant number of years. For some reason, Ennis is probably my most unclear memory of the specifics of the patients and the length of stay but definitely, you know, they'd been there for many years. 11:31

Probably ballpark guess around at least ten, I would imagine.

69 Q. I'm going to pick up then at paragraph 9 on page 4 --

DR. MAXWELL: Can I just ask before you get there, you do say in paragraph 7 that the patients on Ennis would not have been experiencing any acute mental illness or changes in their behaviour. Which wards would the patients with mental health problems or distressed or challenging behaviours have gone to at that time? I know the wards all changed and their configurations changed over the years, but at that point in time, where would the patients with mental illness have gone? 11:32 11:32

A. Movilla A and B would have been the male, and Fintona North and South would have been the female equivalent. I never worked in either of those so I have no experience of them, but that is where the... 11:33

DR. MAXWELL: Okay. Over your time at Muckamore, was there a change in the sorts of needs of the patients? Was there an increase in the number of patients with mental health disorders or behavioural problems over time? 11:33

A. I didn't work in those wards until - when did I go to the core hospital - 2017, so I wouldn't have had an awful lot of knowledge of numbers and admissions and things. 11:33

DR. MAXWELL: That's fine. Thank you.

70 Q. MS. BRIGGS: At paragraph 9 then on page 4, you say that you worked at Ennis Ward until 2009 and you went on maternity leave, and you returned to work in around

2010 when you went back to Rathmullan?

A. (Witness Nods).

71 Q. Then you give a good amount of detail at this paragraph about how Rathmullan closed quite suddenly. You say it closed quite suddenly, and this is halfway down paragraph 9. 11:34

... "following my return, although I cannot recall exactly why. Plans were always being made that all the wards would close in turn when patients were resettled into community placements. However, the closure of Rathmullan was brought forward very suddenly and did not appear to be directly reduced to reducing patient numbers." 11:34

You do say your memory's vague, but can you recall how the sudden closure of Rathmullan affected patients?

A. It was distressing at the time. The patients had to move to Greenan Ward, and neither ward had much preparation time for that so it was very unsettling. The patients were moving to a new area, mixing with new people they potentially had never met before. You had two staff teams merging together with lots of changes. 11:34

I remember the initial days, you know, moving everybody's belongings and things were chaotic, and particularly those first few days to weeks were very unsettled. The patients coped remarkably well but it still was distressing to be suddenly moved to a new 11:35

area.

72 Q. What is your recollection now, looking back, of how well that particular ward closure was managed in terms of, say, how it was communicated to staff and how it was communicated to patients? 11:35

A. My recall isn't great. I don't remember where the instruction even came from initially, I just remember there wasn't much time. And those, the patients in Rathmullan, probably wouldn't have had a lot of understanding, their cognitive ability wouldn't have 11:35 allowed them to have really good understanding of the move, so it was probably a bit of a shock to them. They would have been told they were going but probably until they were there, they wouldn't have known what to expect. 11:36

73 Q. What about staff, how was it communicated down to staff?

A. I don't remember. I think it was just somebody had made the decision, it came down to the ward manager and it was word of mouth among the staff team then, "Did 11:36 you hear the ward's closing, it's closing in three weeks", and it was all a bit frantic. I don't recall any official meetings or notification around that.

74 Q. All right. Thank you very much. You go on in your statement to describe your move to Greenan, which you 11:36 think was in about early 2013, for two years?

A. (Witness Nods).

75 Q. Then it closed, and you think that was in 2015?

A. (Witness Nods).

76 Q. That's at paragraph 10. You go on to describe how you were moved again to Moylena or M4.

A. Mm-hmm.

77 Q. At paragraph 11 then at the bottom of page 4, into page 5, you say how the patients in M4 had severe learning disabilities as well as challenging and aggressive behaviours, and you describe the types of aggressive and challenging behaviours patients had. You say towards the end of paragraph 11: 11:37

"Prior to this time I spent in M4, I would not have been used to dealing with aggressive behaviours of this level and intensity, and I found it very difficult to adjust to working in this ward." 11:37

When you moved to M4, were you provided with any additional training to manage the more difficult behaviours you were now seeing?

A. No, you weren't. You were just moved and "Here's your first day of work", and you relied heavily on the staff who already worked there to guide you and support you. No, there was no training. 11:37

78 Q. I'm thinking then about the support that you got other than the support of your peers and those around you. I mean, was there any formal support in place for that type of move, which seems like it was -- you said it was very difficult? 11:38

A. It was very difficult. And no, at that time there wasn't. There was significant staff shortages within

Moylena at the time. And no, I don't remember there being any support for anybody, even those that were already there and new people coming in or those newly going in. I don't recall any support for anybody.

79 Q. Did you speak to anyone, those more senior, to say you were finding this transition hard at any time; can you remember? 11:38

A. I know the ward manager would have been in regular communication with senior management and raising the issues and the concerns, and then she would have cascaded that down to us on what the responses were. But really the general response that was cascaded down to us was we have no other choice, this has to happen and we have to make it work. 11:38

80 Q. Okay. You later on in your statement - and I'm going to jump there, it's at page 12, paragraph 27 - you give a little bit more detail about M4. Since we're there, I'm going to ask you about it now, okay? So page 12, paragraph 27. You say there in the second sentence that you felt that the care in M4 felt more institutionalised than previous wards you'd worked on. You say: 11:39

"There were a lot of patients together in M4, most of whom likely had various sensory processing difficulties or needs", and you felt that M4 was not the best environment for those patients. 11:39

So, this was 2015/2016 when you were there; isn't that

right?

A. Yeah.

81 Q. Okay. If an institutionalised setting was needed for these types of patients, how could it have been improved for the patients? 11:40

A. Things were moving on but they were moving slowly, and it appeared to me more slowly in M4 than the other wards had been. I mean, it was really basic things like all the patients wore the same type of pyjamas, because these were fire retardant pyjamas that had to 11:40 be used as a safety precaution in the hospital. That moved on, absolutely, but it just seemed very slow to move on.

You know, it was quite a rigid daily routine. Because 11:40 there was only the two-day rooms, as they would have been referred to, so patients were split into two groups, they had to sit together; there was only sufficient staff to supervise these two rooms. You know, there was nowhere somebody could go for quiet 11:40 time on their own if they wanted a bit of peace or relaxation. It was a two-storey building. The dormitory was upstairs so you couldn't allow patients to go up and lie on their bed because you didn't have enough staff to supervise additional areas. So, it 11:41 just seemed slower to be moving on to addressing those type of needs for the patients, I felt, than other wards had.

82 Q. Well, it sounds as if -- assuming that the numbers of

staff couldn't be changed, what could have been changed at that time to make it better for the patients? What smaller type changes would you have liked to have seen at that time?

A. Patients being able to choose where they sat, where they went, who they were with. They had very limited opportunities for social outings. I mean, some of their behaviours would have been difficult to manage out in social environments but certainly we didn't have the opportunity to try that. You know, there was one bathroom that everyone had to take their turn to use. At this stage the Cranfields had opened and they had en suites and things were moving on, but M4 was really behind. They knew what they needed to do and that's what they were doing in the new building of the hospital but these patients just hadn't been fortunate enough to move to the new hospital; if that's the right word, fortunate. Environmentally, that, you know, additional bathrooms, en suites, additional sitting rooms wasn't something we could facilitate. 11:41 11:41 11:42 11:42

83 Q. In terms of the lack of things to do for patients, you have touched on it and you mention it in your statement about M4; presumably if the patients were lacking in that type of stimulation, so were staff?

A. Mm-hmm, yeah. Absolutely. 11:42

84 Q. If we go back to page 5 then, where we were. At paragraph 12 you describe how you worked in Oldstone as well for a time prior to 2016. You describe at paragraph 12 how patients in Oldstone, they were

reintegrating into the community and they were more independent. You describe Oldstone in detail; okay? You describe how it had individual houses, almost like community placements, and patients did their own things like cooking and cleaning. You go on to say that both M4 and Oldstone closed in 2016. 11:43

A. (Witness Nods).

85 Q. Why do you think Oldstone was closed in 2016 when it seems as if it was very well set up for resettlement, that there were so many patients in Muckamore needing to be resettled at that time? 11:43

A. I have no idea. I don't know who the decision-makers were and why these decisions were made.

86 Q. Overall in terms of all the closures you saw - Greenan, Oldstone and M4 - okay, those three later ones, let's focus on those, okay - can you reflect now on how well those closures - they were less sudden than the closure at the other ward - can you reflect on how they were managed, those particular closures, at the time? 11:44

A. No better, I don't feel. I feel they were all very similar. You know, they felt quite quick at the end, and there were always a few - not within Oldstone thankfully, it was probably the best, but certainly within Greenan or M4 - there were always those last few remaining patients that had to move to another ward in exactly the same way. You know, the wards never emptied with discharges. So if you were the unfortunate one to be left, that was managed in the same way. 11:44

87 Q. What about for staff, how was it managed?
A. Still the same thing, you still got told ward's closing in three weeks time and you are moving to whatever the new ward would be. It was no different.
88 Q. You go on in your statement then to describe how you and the patients that were left went from M4 to Erne? 11:45
A. Hmm.
89 Q. And you spent a year on Erne. Then in April 2017, you went to Cranfield 2?
A. Yeah. 11:45
90 Q. You describe this at paragraph 14 - we're on page 6 - that entering Cranfield 2 was your first time entering what you say was the core hospital. That's what people called it; okay?
A. (Witness nods). 11:45
91 Q. You give a good amount of detail in your statement about what the core hospital is. One thing you say early on at paragraph 14, you say:

"Within the core hospital there was a different model 11:45
of care as it was here that patients who were acutely mentally unwell or who were displaying significant behaviours of concern were admitted, and these patients were not delayed discharge but were actively receiving
treatment." 11:46

Can you give the Inquiry a little bit more information about the core hospital? For example, okay, if a patient wasn't ready to be discharged, would they

normally have just stayed in the core hospital?

A. Yeah, they would have. The theory was that Cranfield 1 was the male admissions; that's where you went for your initial period of assessment and to commence treatment. Then you would have transferred to Cranfield 2, where the treatment would have continued, and you would have remained until your community placement was identified and ready. 11:46

I did only go in in 2017, so it wasn't functioning really from then on as it should have. So again, my experience maybe isn't as accurate of it when it was functioning at its best. 11:46

92 Q. You go on in your statement to say you worked in 2019 on Cranfield 1 as a Band 6 Deputy Ward Sister and then -- 11:46

DR. MAXWELL: Sorry, just before you move on. You talked about when you moved to M4 and you described it as institutionalised, that the care wasn't perhaps as you might have hoped it could be, and you talked about some of the reasons for that. When you moved to Cranfield in 2017 - this was the shiny new hospital - did you have any concerns about the standard of care patients were getting there, or were these all addressed by the environmental advantages of the new hospital? 11:47 11:47

A. I didn't have any concerns because it was new, it was purpose built, all the AHPs and additional services was going in. It seemed to be amazing. This is where you

wanted to be and where you had access to everything, and it appeared to be the best of the best, I suppose, within the hospital. So no, I didn't have concerns.

DR. MAXWELL: So as a nurse, you were able to deliver the standard of care you wanted, whereas in M4 there had been constraints on that? 11:48

A. Yeah.

DR. MAXWELL: Thank you.

93 Q. MS. BRIGGS: You went in 2019 to Cranfield 1, as I was saying, and you were a Band 6 deputy. Then you became a Band 7 ward sister in Killead? 11:48

A. Yeah.

94 Q. And then you left Muckamore after that; isn't that right?

A. Yeah. 11:48

95 Q. Okay. We have gone through the different wards there, okay, and you give detailed information in your statement about the differences between the wards, and you have already given some evidence about that this morning. I just want to pick up on one thing you say about that. It's at paragraph 24, page 11. You say there in the second sentence: 11:48

"Some wards were more authoritarian than others but they all followed the same policies and procedures that MAH had in place and there was always a senior nurse manager (Band 8) overseeing. The care needs and therefore daily tasks of staff varied greatly from ward to ward due to the different patient groups that 11:48

occupied each ward."

Would you be of the view now, looking back, that differences between wards were mainly down to the differences between patients and their abilities and the levels of their challenging behaviour rather than, say, the individual style of ward managers?

A. Yeah. No, every ward was so different because the patient group was so different. I was never any more than two years on a ward so I was never really -- I was always learning, do you know? But yes, the patients were so different. Every time you went in, it was completely new, you didn't know what to expect, you had to start all over again, learning from the start.

11:49

Managers have different styles. I suppose some were more approachable than others, some were easier to talk to, but the policies and procedures were the same. The expectations and standards of care had to be met the same way, no matter where you were.

11:50

DR. MAXWELL: So can I just clarify, you were saying that the ward managers or ward sisters, or whatever we are calling them, had different styles. Did those different styles have any impact on the care delivered to patients?

11:50

A. No.

DR. MAXWELL: Thank you.

96 Q. MS. BRIGGS: What about the likes of MDT, multidisciplinary presence on the ward, how did that

vary between wards?

A. Within the resettlement wards, the MDT input was a lot more limited. They would have had monthly - certainly I recall Rathmullan would have been monthly - reviews; annual reviews for each patient but they were scheduled 11:50
monthly to cover everybody. That monthly visit from the consultant was probably the only time they entered the ward. I mean, you didn't have daily or weekly reviews. You know, when you get to somewhere like Cranfield 1, which was an admission ward, they had 11:51
daily PIPA meetings and you had psychology services, your consultant psychiatrist, behavioural services, everybody was involved in that. So it really depended on the ward, the level of input that was required.

11:51

I suppose if the patients' needs were changing more often, that needed to be reviewed more often. I think Cranfield 2 initially was fortnightly MDT meetings, where everyone was addressed fortnightly. So again, every ward functioned differently and it was based on 11:51
the changing needs of the patients and how often that would need reviewed.

97 Q. I'd like to pick up now on a couple of the themes that you deal with in your statement. Throughout your statement, you give lots of information about the 11:51
culture and the atmosphere at Muckamore and what it was like as a place to work. At paragraph 17 at the bottom of page 7, you say this:

"Overall, the culture on all the wards that I worked on was good. Things weren't always ideal, but overall the atmosphere was good and everyone did their best to make the patients' time there as positive as possible."

11:52

Is there anything you'd like to add to that? For example, when you say that things weren't always ideal, what do you mean by that?

A. I mean, over 20 years is a very large timescale. In every employment there's going to be good times and bad times; there's difficult times when there may be staff shortages, when maybe you have a patient who's particularly unsettled for a few weeks. That is generally the nature of inpatient care. So I find it hard, it's a very generalised statement, to cover over 20 years. Just my overall feeling is that people always tried their best to make the environment as good as -- not environment but the atmosphere as good as possible - you know, very jovial, doing what they can to make every day as easy as it could be.

11:52

11:53

11:53

98 Q. And when things weren't so good, what type of things would have caused that?

A. Like, you may have had a patient who was particularly unsettled and unwell, displaying high levels of aggression, and you knew every shift you were going in, you were going to face these high levels of aggression. That could have continued for weeks or months. They were difficult, knowing that that's what you're going into. Then you would have had periods of time where,

11:53

you know, everyone was well and it was a lovely place, and you went in and you could be doing out shopping and everything was very relaxed. But just probably the levels of aggression, unsettled behaviour, staff shortages. If you had a lot of people off sick, then you knew you were going to have a few difficult weeks with that. Just those sort of things would have made the difference. 11:54

99 Q. At paragraph 21 on page 9, this is perhaps one of the not so good things that we've touched on there, okay. You're describing at paragraph 21 how staff morale was poor, you say, when you worked on M4 and Cranfield 1. I'd like to ask you about M4, because particularly when you worked on M4, which was 2015/2016 - that was before what came out about Muckamore in 2017 - you actually describe it there in paragraph 21 that poor morale made it one of the hardest wards to work on. 11:54

What gave rise to the poor morale amongst staff at that time? 11:55

A. I don't know what had happened prior to me starting there, I just know when we went, there was very, very little staff. It was very difficult. New staff were coming in not being familiar with the patients, their needs, how to manage any challenging behaviour. The few remaining staff who would have known the patients, they were trying to look after those patients, who could be difficult, whilst trying to induct us and support us coming in and getting used to the ward. 11:55

There was a lot of pressure on those staff. So obviously there the morale was poor between them. We are the ones, you know, who are left trying to manage all of this, and it was difficult. We were going in and you're sort of thinking why are we being put in here, this is a really difficult ward, it's really short staffed, why are we being sent in here to sort this out? 11:55

There was quite a bit of turnover in the Band 6 and 7 staff at the time; I can't clearly recall it all. So there wasn't managers or leaders there, I suppose. I mean, the ward manager I worked with there started at the same time as me, coming from Greenan, which is a very different ward, so she's in a new ward where there's poor morale, trying to learn the ward, trying to support all the staff on both aspects. So it was just difficult for a while. 11:56

100 Q. How, if at all, did that poor morale affect patients?

A. I don't know. You know, they didn't, to the best of my knowledge, visibly show any distress or upset or anything that I could see. But I wouldn't have known these patients so I wouldn't have known how they would have presented prior to my time there. It would have been maybe difficult for them, I suppose, new staff that don't know them, we would have been getting them up and getting them dressed and ready, and wouldn't have known their preferences, which, that's the nature of a care environment. But that would have been a bit 11:56 11:56

difficult for them.

They would have had to sense the atmosphere but couldn't communicate to us probably how that made them feel, if at all they did feel it. I don't know. 11:57

CHAIRPERSON: Can I just ask you, are you describing the period -- we're in 2017.

A. 2015.

CHAIRPERSON: We're still in 2015, so this was long before staff began to be suspended and all that sort of thing? 11:57

A. (Witness Nods.

CHAIRPERSON: So there are obviously other issues affecting staffing?

A. (Witness Nods). 11:57

DR. MAXWELL: So you are saying that these are wards where patients had mental health disorders, challenging behaviours, you're also saying that the staff who were new weren't used to managing this group of patients and there wasn't a particular training programme, you were learning on the job? 11:57

A. (Witness Nods).

DR. MAXWELL: So would it be reasonable to assume that at this time there were patients whose needs were not being met because the nurses didn't have the skills to look after them and this might have been making their behaviour worse? 11:58

A. Potentially, yes. You know, you relied on -- there were some staff who already worked there; you were

relying on them taking on most of the care and directing us to --

DR. MAXWELL: So at this time when you transferred to M4 in 2015, what percentage of staff do you think were new to working with this type of patient need? Was it 50/50 of existing staff, or more or less? 11:58

A. Probably 50/50, if not a bit more. But then it was difficult, so my recall mightn't be as accurate because sometimes you --

DR. MAXWELL: I understand. 11:59

A. -- see it as worse than it was when you were in a difficult situation.

DR. MAXWELL: But potentially half the staff didn't have the specialist skills to deal with people with behavioural challenges? 11:59

A. And I will say too to take into account - though this to me was the most difficult ward with the behavioural challenges - it probably wasn't for other people who had experience of challenging behaviour; it was just my first time experiencing it. And those people -- and later in my career working within the Cranfields, had I gone to M4 after that, it probably wouldn't have been so challenging for me. It was the fact that it was my first experience with it, you know? 11:59

DR. MAXWELL: Thank you. 11:59

101 Q. MS. BRIGGS: Was there anything done at senior management or management level to improve the staff morale on M4 in 2015 and 2016?

A. I don't remember anything being done. If it was, it

certainly didn't work because I've no recall of it getting any better.

102 Q. All right. You go on in your statement at page 10, paragraph 22, to describe how the allegations of abuse at Muckamore came out in 2017 and how that was a really unsettling time for everyone. You were working on Cranfield 2 at the time; okay? 12:00

A. (Witness Nods).

103 Q. Throughout your statement, you give lots of information about that; okay? 12:00

CHAIRPERSON: Sorry, Cranfield 1 or Cranfield 2?

MS. BRIGGS: Cranfield 2. Paragraph 22.

CHAIRPERSON: Okay. Yes.

104 Q. MS. BRIGGS: Throughout your statement, you say that there were lots of difficulties, okay? You talk about staff suspensions, you talk about other staff leaving, you talk about poor morale. What support was offered to staff during that time? 12:00

A. I don't recall any outside peer support and the ward manager. There was very little information, and that was the most difficult part. Nobody knew what was happening, why it was happening. You know, we knew there was allegations of abuse; nobody had any other detail. And there was nobody, I suppose, at our level that would have had any details, so it would have been very difficult for anybody to support us because they were in the same situation. You know, no information. So that was probably a significant factor, the unknown. 12:01 12:01

At ward level, there was nobody else would have known it so, you know, your ward manager, potentially even your senior manager, I wouldn't have been thinking that they would have known anything.

105 Q. At paragraph 40 of your statement on page 19, you do mention, halfway down that paragraph, that staff were provided with the number of a counsellor. Was that during the time of 2017, or was that post-Covid because you mention both. 12:01

A. It was in relation to post 2017 -- 12:02

106 Q. Okay.

A. -- but it took a period of time to come into place.

107 Q. Okay. You say there about that, staff being provided with the number of a counsellor. You say there was no feedback shared with the Belfast Trust as to what the counsellor discovered or the level of trauma and distress she was seeing in the people she saw, and if the counselling was effective. How do you know that there was no feedback shared with the Trust about that? 12:02

A. Well, it was her word. I had asked her, you know, was she sharing any of this information and she told me no, it wasn't part of it. It was independent counselling, so she absolutely would never have shared any detail of any particular person. But, you know, I had asked her out of interest did she share themes or anything, and she said no, all she shared was the numbers of people that she seen. 12:02 12:03

CHAIRPERSON: But, as she said, she wouldn't have been able to, would she, because counselling is effectively

privileged?

A. Yes. So she was restricted, she couldn't share it, but I just personally had felt - and that's just my opinion - but she would have been seeing themes, generalised themes, people presenting, and there probably could have been learning that she could have shared in some way. But that wasn't part of the process, so... 12:03

CHAIRPERSON: All right.

108 Q. MS. BRIGGS: Earlier on in that paragraph, you mention that during this time of crisis in Muckamore, which is how you put it, you say that you recall yourself raising staff welfare concerns during various meetings as you felt that staff needed some form of support following the events in 2017. What was the response, if any, when you raised those types of welfare concerns? 12:03

A. There was no response, or maybe somebody might have made a comment "Oh, yes, that would be a good idea". But there was never anything further came of that. 12:04

109 Q. You say that you think management could have done better?

A. (Witness Nods).

110 Q. Okay. When you're talking about management in this context, who do you mean? What level of management? 12:04

A. I don't know. I don't know, I don't know who was responsible or would have been responsible for putting those supports in place. I feel I don't know is something I say quite often and, post 2017, that is

what everyone said. Because of the investigation and confidentiality and so much was going on, there was a real lack of information about everything.

111 Q. How do you think it could have been better handled?

A. You know, there are lots of support services available that could have at least been offered, whether people availed of it. You know, stress control. I don't know; they exist. You know, post-Covid counselling exists, you know, as an identified trauma. So I am sure there are supports that could have been offered. People may or may not have availed of it and it may or may not have been helpful, but certainly I don't feel enough was done to offer that to staff. 12:04 12:05

112 Q. With everything that was going on in Muckamore at that time and how difficult - and you say it was - why did you choose to stay? 12:05

A. For the patients. You know, somebody still had to look after them, and there was a sense of responsibility and duty around that. I've always said, as any member of staff did leave, it made it harder for those that remained to leave because you felt even more that sense of responsibility, that somebody had to remain to look after these patients. It was very difficult for me personally. And I did always and had always loved my job. It was never about the caring for the patients that was the issue, it was about the stress as a result of what was going on at the time. You always hoped it would pass. You always thought, right, we know something has happened, we'd have no detail around it, 12:05 12:06

but hopefully it will, you know, all be addressed, it will all be resolved, there could be a great future ahead. You lived in hope of that but eventually then you lost that hope. But I will say leaving Muckamore was one of the most difficult decisions I made and have had to do. 12:06

113 Q. Why do you say that?

A. Because you know you left those patients behind with less people to look after them.

114 Q. At paragraph 23 on page 10 you describe, you know, around this time working in Cranfield 1 in 2019. You say that there were a lot more agency staff as staff were suspended. Agency staff, were they adequately skilled for the patient needs on that ward? 12:06

A. Most of the agency staff - and again I wouldn't have numbers, so I'm saying that from my opinion - were mental health nurses. So their training would have been around mental illness and they would have had very little to no training specific to learning disability. That didn't take away from their ability to look after people with a learning disability but it is a very different role. And they would have told you themselves when they came in they had no idea, you know, the people they were coming to look after, how to learn to communicate with them, the expectations. So, I'm not going to say that they weren't well enough trained but there is very definitely a difference in mental health and learning disability. I don't want to say that mental health nurses can't carry out that 12:07 12:07

care, but yes, I think learning disability nurses bring a different skill set and a different level of training that was required.

DR. MAXWELL: Was that apparent to you because you were Band 7 at this time? A 6 or a 7? 12:08

A. I think it was apparent to everybody but maybe not with the same level of knowledge. I suppose as a manager, the staff would have been speaking to me and telling me what they would have had having difficulties with. I would have had a better knowledge, I suppose, of their 12:08 training and their registration than others might have.

DR. MAXWELL: So was this putting more pressure on the RNLDs?

A. It was, yes. But whether that was linked to the fact that the RNLDs were under more pressure due to the 12:08 staff that the agency staff were mental health, or just the pressure was because they were new and their registration was irrelevant, they were new to these patients, they were new to learning the ways of the ward and learning to communicate with them, so... 12:09

DR. MAXWELL: So you talked about the difficulties of working with people with mental disorders and challenging behaviour when you first went to M4, and you were an RNLD; so if you're an RMN, it's going to be more difficult to pick it up. Do you think the 12:09 patients responded differently to these agency nurses?

A. Yes. I suppose just a fact of the way it was, a lot of these agency nurses were not from Northern Ireland, be it England or elsewhere, and the patients at Muckamore

would never have been exposed to that before, certainly. The patients who have been in Muckamore for 40 years had probably -- had never maybe seen somebody who was black. That's no disrespect to anybody, but that didn't happen in Muckamore before a certain year.

DR. MAXWELL: But are you saying more than being black, they were actually overseas trained? There's a lot of black British nurses. Are you saying that a lot of the agency nurses had not trained in the UK?

A. Yeah. And through an agency - and I did discuss this on multiple occasions at Muckamore - because they were recruited through an agency, we would not have had oversight of their training. We would have been given assurances that their training was completed but we would never have seen the content of it. So an agency staff from England who had completed mental health training in England would not have been familiar with the Mental Health Order in Northern Ireland. You know, the same as our RQIA inspections, they would have referred to the CQC, is it?

So I did always query the fact that we didn't know the content of their training. We were assured they had it but what it contained, I don't know. That was just due to the fact that they were different employers.

DR. MAXWELL: So the combination of having a different training, being originally trained overseas, was having this impact on patients who were just not used to that degree of diversity?

A. Yeah.

DR. MAXWELL: Thank you.

A. And positive behaviour support training is not included in any other training. Mental health nurses would not receive positive behaviour support training, which is a very different, I suppose, ethos maybe isn't the right word, but it's a very different management. So that was difficult for mental health nurses to come in and adjust to the PBS, positive behaviour support, way. There was no way of accessing training on that without coming into working in the field of learning disability. 12:11 12:11

DR. MAXWELL: Thank you.

CHAIRPERSON: Sorry, what proportion of the patients that you were dealing with were on positive behaviour support plans? Were they all? 12:12

A. By the end of my time, yes, they were all on positive behaviour support plans. But it's not just about the plan, it's the underlying values of positive behaviour support and that knowledge of the management of challenging behaviour. You know, it's not even patient specific, it's that lack of -- it's, you know... Without going into too much detail, you know, setting up capable environments; you wouldn't do that in mental health and you wouldn't have knowledge of that in mental health. 12:12 12:12

CHAIRPERSON: In relation to the agency nurse who came over to assist the hospital, once you got an agency nurse, did they tend to stay or was there a lot of

turnover within that group of agency nurses?
A. Both. You didn't know what you were going to get. So some people did come in and did stay and were very valued members of the staff team, but I do believe they would all tell you it was difficult to get to that. 12:13
There were others that came and absolutely straightaway acknowledged that they would find this work difficult and had no intention of staying. I think that was always one of the difficulties with agency staff; you didn't know if they were going to stay. And they had 12:13
no commitment, they didn't have to, and they didn't have to give you notice that they were leaving. So you had invested a lot of time in integrating them into the team, which is absolutely what you wanted to do, but sometimes people could say, well, actually, this isn't 12:13
for me and I'm away, and you had to start all over again. That was a continuous --
CHAIRPERSON: So, on a ward - and maybe this is too difficult to estimate - but I'm quite interested in how many, I will call them regular nurses and health 12:13
workers you would have had, in other words northern Irish and worked for a while at Muckamore, how many of those would be agency nurses who stayed and how many would be passing through?
A. I don't know. That's difficult. I suppose -- 12:14
CHAIRPERSON: Would the majority be agency or would the majority be regular staff?
A. About 50/50 probably.
CHAIRPERSON: Right.

A. It depended on the ward as well. It may have been that in certain wards - and I do remember - the entire nursing team of registrants was made up of agency but you had most of your health care assistants made up of substantive staff. That could have changed in a different ward. You know, it was maybe 50/50 registrants. It just depended; every area was different.

DR. MAXWELL: So when you were on Cranfield 1 in 2019, what percentage of the registered nurses were agency? 12:14

A. By the time I left Cranfield 1, or certainly a very short time afterwards, there were no substantive registered nurses in Cranfield 1.

DR. MAXWELL: I think you say you were the last...

A. I wasn't the last to leave, I don't think, but I wasn't very far away, and it was left that there was none. 12:15

DR. MAXWELL: So who was providing the shift leadership; was that an agency nurse?

A. Yes, it was.

DR. MAXWELL: Who was not learning disability trained? 12:15

A. Yeah. May not have been disability trained. There were a few learning disability trained nurses but they were the minority.

DR. MAXWELL: Essentially the person in charge of the shift would be, A, not substantive; B, overseas trained, i.e. not UK trained, let alone not Northern Ireland trained; and not LD trained? 12:15

A. Yeah.

DR. MAXWELL: Did you raise concerns about this,

because this sounds like a risk?

A. I suppose on reflection I don't know if I raised concerns in the right way, but we raised concerns daily, and there were safety huddles daily, and you spoke to senior managers regularly and you verbally raised these concerns. On reflection, maybe there would have been a better way to do it. 12:16

CHAIRPERSON: Again, when you refer to senior managers, just because I am a civilian, as it were, who do you mean by a senior manager? 12:16

A. Our Band 8A.

CHAIRPERSON: Band 8A, yes.

MS. BRIGGS: Panel, if there is appetite for a break, I'm wondering if now might be time to do it? I think I have about 25, 30 minutes to go. 12:16

CHAIRPERSON: Sure. Yes.

MS. BRIGGS: I'm content to keep going, it's just if the Panel want.

CHAIRPERSON: How do you feel? Would you like a...

A. I'm happy to keep going. 12:16

CHAIRPERSON: If at any stage you do start to flag - obviously it's important that you are mentally fully with us - so if at any stage you do want a break.

A. No problem. Thank you.

CHAIRPERSON: Just let us know. Ms. Briggs, are you okay to continue? 12:16

MS. BRIGGS: Yes. Thank you, chair

CHAIRPERSON: We'll try and keep going and see where we go to.

115 Q. MS. BRIGGS: I want to go back to a topic that you touch on, which is institutionalised type care. At paragraph 32 on page 14 you say there that you never witnessed any abuse during your time at Muckamore.

12:17

"Looking back at my time there, I see how institutionalised the care was at the beginning of my career, but that was how things were done then. In my personal experience, there was no intentional abuse, and practices have developed and improved over the years as they did with all institutions and care settings."

12:17

Looking back with today's eyes, okay, on the 20 years you were there and the start of those 20 years, could the more institutionalised care that you saw at the beginning of your career, could that now be considered abusive?

12:17

A. You know, there is institutional abuse, it is a defined category of abuse. So absolutely, it probably could. We didn't see it that way at the time; and whether that's okay or not. So, yeah. But practice has always moved on and always will continue to do so. When you reflect back to any time, what we know now, we think, oh flip, we would never have done that. But it wasn't that the practice was abusive, it's just it keeps getting better with evidence and research.

12:18

12:18

DR. MAXWELL: Do you think over the period of your career, the emphasis on a human rights approach

changed?

A. Yeah, absolutely. The positive behaviour support, when it came in and it changed, you know, staff's thoughts, I suppose, and the underlying human rights, that all made massive differences, it did, but positive behaviour support wasn't a known thing 20 years ago. It also took time to embed that in. You know, when you bring in anything new like that, it takes time to embed that. 12:18

We were always trying to do better. I know in MAPA, safety intervention, physical restraint changing - it's changed names so many times - those thought processes were always there but they maybe weren't formalised as positive behaviour support. As training developed and more ideas came through, you know, I always seen it getting better in that the human rights coming through more and more. Yeah, it did move. 12:19

DR. MAXWELL: So was there a gradual movement or was there a sudden point in time when everybody said no, the philosophy's got to change? 12:19

A. Gradual. It was a gradual movement.

DR. MAXWELL: It was gradual over that time?

A. (Witness Nods).

DR. MAXWELL: Thank you. 12:19

116 Q. MS. BRIGGS: Page 16, paragraph 35. You describe in detail in that paragraph the use of allocation sheets to allocate duties to staff, which you say was done by the nurse in charge and then later by yourself when you

moved to Band 6/Band 7; okay?

A. (Witness Nods).

117 Q. Were those allocation sheets ever audited by anyone to the best of your knowledge?

A. I don't remember any formal audit process, no. 12:20

DR. MAXWELL: So if then what I'm imagining, they have a patient's name, they have a list of things, maybe tasks like what sort of personal hygiene they need, any activities, any appointments that day and then who was assigned to that; is that correct? 12:20

A. Yeah.

DR. MAXWELL: Would staff write on the allocation sheet when they had completed that?

A. No. And staff generally didn't write on the allocation sheet, it was the nurse in charge wrote on that. I 12:20 suppose the general feeling was you couldn't change the duties you've been allocated, they were your responsibility and if you couldn't carry them out, you were to go in the nurse in charge and discuss that with them. So it was limited, the amount of people that 12:21 would have wrote on that sheet.

DR. MAXWELL: So we heard yesterday from a witness about the duty sheets that used to go to the nursing office that stopped happening when you moved to PARIS. So there was an emphasis on the records of the 12:21 individual, but the allocation sheet and the duty sheet looked at the ward as a whole. So how, as the nurse in charge of a ward, did you manage to keep track on whether all those care activities had happened if

people weren't positively telling you that they had been done?

A. You had to go and physically check but that was part of your oversight of the ward. You would have been walking around, you would have been visible, I mean you weren't closed away in an office, and you would have said do you have that done yet; do you know you are down for that, make sure you don't forget to do that. It was a more informal way but it was part of your oversight of the ward, you had to be on the ward, speaking to people. 12:21 12:22

DR. MAXWELL: But you didn't document that oversight, that was in your head?

A. Yeah.

118 Q. MS. BRIGGS: You give a great deal of information to the Inquiry about admissions and particularly family involvement at around that time. You say at paragraph 46 - and this is on page 22 - that you yourself didn't have any experience of any emergency admissions during which family could not be supported to look around the ward at the time of admission. 12:22 12:22

A. (Witness nods.

119 Q. The Inquiry has heard evidence from many family members that they were told that they could not visit their patient relative in the first few weeks of admission. Is that something you recognise as having happened elsewhere in the hospital, even if you yourself didn't experience it? 12:22

A. I don't recall ever hearing about families not being

able to visit for periods of time. I do recall hearing that families couldn't enter a ward for a visit at that time due to the ward being unsettled and risks of potential aggression and things. But it was never that -- I have no recollection or experience of anybody not being able to visit for a period of time. You might have had a conversation with a family, you know, how do you think they're going to cope and manage with this admission, do you think seeing them is the best thing? Maybe with agreement of a family, I suppose, is the only way I could see it that the thought may have been that it would make them more unsettled if they didn't understand why a family was leaving. But I wouldn't recall or understand why somebody was told they couldn't visit for a period of time. 12:23 12:23 12:23

120 Q. If that did happen, or where it did happen, do you recognise that that might have been very difficult for families?

A. Absolutely. A family was going to be desperately worried about their relative that was somewhere; they didn't know where they were, they didn't know what to expect. For the few admissions I had, it was always very important that the family seen where their relative was and had a good understanding of what the care would entail. 12:24 12:24

121 Q. Thank you very much. I'm going to move on to something else now, okay. You give evidence about incident reporting and also the dangers of working at Muckamore. That's something that I'm going to ask you a little bit

about now, okay. Page 20, paragraph 42, this is on the theme of incident reporting, first of all, okay. You describe how, when you were a Band 6 and a Band 7, Datix reports would have come to you and you would review them and investigate and so on, okay. You say there towards the end of that paragraph:

"It was common to see the same types of incidents reoccurring repeatedly, such as patients displaying aggression towards other patients and staff. The reasons for this was often known and management strategies were put in place."

If strategies were put in place, how did incidents or why did incidents reoccur?

A. A lot of incidents of aggression and things were a communication for the patients. I'm trying to recall specific things. Do you know, there was maybe a patient who, if they wanted something, would have grabbed you by the wrist and would have scratched you or dug in their nails, but it was a communication of them saying can you assist me to get whatever it is I want, or I am distressed and this is my warning signs that I am distressed. So a lot of them were repetitive because they were, I always feel, a communication or a known behaviour that they displayed frequently; it wasn't a sudden, unusual assault. Because certainly when you got those, you absolutely had to do a very thorough investigation because something must have been

going on.

122 Q. But the likes of a scratch on the wrist, if that kept happening, presumably then, based on what your evidence is in your statement, a strategy would be put in place that presumably would try to prevent that happening again? 12:26

A. Yeah.

123 Q. So why did things like that keep happening?

A. Your strategies would have been in your positive behaviour support plan, but there were many behaviours patients displayed that we couldn't put other things in place. You would have tried, absolutely, and you would have followed all your steps in your positive behaviour support plan, but there was a very large number of behaviours that, despite all your attempts to manage and put these strategies in place, that didn't change. 12:26 12:26

PROF. MURPHY: Could I ask you was there someone who would be logging challenging behaviours and looking at whether the management strategies were working, be it one of the behavioural therapy nurses or a psychologist? 12:27

A. Yes. There would have been a behaviour specialist nurse involved in every patient's care in the last number of years anyway. They would have attended your multidisciplinary team. They always would have been discussed at your multidisciplinary team meetings, depending on the frequency of the ward. All incidents were on Datix, so you had a record there; they were all recorded in patients' notes. They were all shared then 12:27

in latter years in your live risk and governance meetings. That would have allowed outsiders, I suppose, to hear that the same incidents were happening and maybe having different opinions and thoughts and suggestions and different questions. So there was always a wide range of people aware of the incidents and reviewing them and discussing them and thinking about them. 12:27

PROF. MURPHY: Thank you.

124 Q. MS. BRIGGS: When those incidents are being reviewed and looked at, say it might have been the case that a patient had more challenging behaviours displayed when, for example, there was more PRN or fewer staff on duty or fewer day activities, were those type of trends being looked at; do you know? 12:28

A. Yeah. That would have been through your multidisciplinary team and also through your live risks and governance. You would have seen, right, we have 20 incidents this week as opposed to ten, what's going on, give us a bit of context around this; do we know what the contributing factors might have been? It would have been addressed at those. 12:28

DR. MAXWELL: Can you say a little bit more about the live risk and governance? Was there a separate team of people looking at the Datix forms? 12:28

A. So at ward level you would have compiled the report and you would have put the exact number of incidents that were reported on your ward that week.

DR. MAXWELL: So that was the responsibility of the

ward nurses?

A. Yeah.

DR. MAXWELL: There wasn't an information officer separately compiling this for you?

A. No, it was the ward nurses, and you put a bit of detail of every incident. Then on the live risk and governance meeting... I can't even remember what all -- 12:29

DR. MAXWELL: So the risk and governance meeting was a different meeting from the MDT?

A. Yes. Yes. It would have had your assistant service manager, clinical director, you know, higher level managers than the senior nurse managers at 8A. The higher level managers would have attended that meeting. 12:29

DR. MAXWELL: So the clinical director would have been aware of all these incidents -- 12:29

A. Yeah.

DR. MAXWELL: -- and any trends that had been identified in them?

A. Yeah.

PROF. MURPHY: So as a staff member, when you saw that management strategies were being put in place and yet incidents were still occurring, wasn't it very frustrating to you and didn't you start to think to yourself, well, actually, maybe this is because there are environmental things that we're not able to change, like very noisy, very distressed patients, overcrowded, staffed by people who don't know them very well et cetera, et cetera? 12:30 12:30

A. Yeah. You would have tried to identify all those

things and tried as best as possible to put something in place, you know, providing somebody with quieter time and giving them the opportunity to leave, if that was something that you could do.

12:30

With regards to frustration, I suppose there's a certain level. Within learning disability, there will always be incidents and, due to communication issues and cognitive impairment, this will always happen. So for what we would refer to as low level incidents that 12:31
were a commonly known part of that presentation, you didn't get frustrated, because you just knew that was how that patient was and this was how you managed it. It would have been more serious incidents. You know, you might have got frustrated if you felt they weren't 12:31
being reviewed and trying to change and put plans in place, but I don't really recall much about serious incidents not being reviewed. It was a full multidisciplinary team trying to brainstorm and think how they could be managed. 12:31

DR. MAXWELL: But was there a frustration that there were things you couldn't change? So there might have been a very detailed review of a serious incident, but if the conclusion was that the environment wasn't conducive, that the patient was distressed by other 12:31
patients, there was nowhere for them to go, they were being looked after by staff who didn't know them, if this was being identified, was there not a frustration that the Trust wasn't doing anything to change those

environmental conditions?

A. There was a frustration around the inability to change them, yes. And they were constantly addressed and constantly passing on, you know, this patient absolutely requires discharge, you know, pushing for discharge panel, pushing for discharge panel. But there was an understanding that there were certain things that couldn't be changed, and, frustrating as that may be, you did your best to speak to the right people to change it if you could. We're always working towards changing it but there were a lot of things that just you couldn't. 12:32 12:32

DR. MAXWELL: Well, when this went to the Risk and Governance Committee, which as I understand it you didn't attend, or did you attend the Risk and Governance Committee? 12:32

A. The live risk and governance? I did attend.

DR. MAXWELL: Was there a sense of what got escalated? Because in a governance system, these committees are supposed to identify things they can't resolve and report them up to the next level and ultimately to the Trust Board. But one of the things that seems to have happened is that the Trust Board were not aware of these risks. So at those meetings, was there ever a discussion that this is such an issue, we need to escalate this to the next level? 12:33 12:33

A. No. From my perspective, it was information sharing that we were passing to our next level, and we didn't know what would have happened after we shared it.

DR. MAXWELL: You didn't know whether they escalated it?

A. No.

DR. MAXWELL: Rather than they didn't escalate it?

A. Yeah, we just didn't know. 12:33

CHAIRPERSON: But by having the meeting, you were escalating it as far as you could?

A. Yes. We were escalating it to our next level, that was our process, but we would never have known what happened after that. 12:33

CHAIRPERSON: That was beyond your...

A. Yeah.

PROF. MURPHY: One last question before we go back to you. Some of the families told us in their evidence that they felt their sons or daughters got worse when 12:34 they got into Muckamore Abbey Hospital. Was that something -- does that ring true to you?

A. Yes, it does. Coming into Muckamore, you're coming into a restrictive environment. It's not a normal home environment, so that alone would have distressed some 12:34 people. You had significant restrictions on your quality of life. You couldn't go out shopping when you wanted to, you couldn't even make yourself a cup of tea most of the time without staff assisting you to do it. So that would have distressed patients; that would 12:34 distress any of us.

Also, within learning disability there has always been a bit of an element of learned behaviour. So

behaviours or even foul language, for example, that people would never have seen at home, when you come into hospital you are going to see people maybe doing things and saying things that were new to you, and some people picked up on that. There could have been more historically - maybe not so much in recent times but that is debatable - a patient who was challenging or aggressive or swearing was getting staff attention, so there was nearly like a negatively learning, "Oh, if I start swearing or hitting out, I'm going to get attention and maybe this is the best way I can go about getting that." Unfortunately, that is a really negative situation of being in group care. That has always been known. 12:35 12:35 12:35

PROF. MURPHY: So for families, their loved ones were going into the hospital because they couldn't cope.

A. Mm-hmm.

PROF. MURPHY: They were then feeling that the behaviour was getting worse, you were feeling the behaviour was getting worse; what did you feel the way out of all this was? 12:35

A. You manage what you could within your ability. You attempted to, do you know, not expose people to those things if you could. You tried to isolate incidents and keep people away. We had our positive behaviour support plans, you know, we didn't reinforce negative behaviours and we tried to take away from that. You did what you could, but there was a certain amount that you couldn't remove. 12:36

But it is the same in normal life as well. If a child goes to school, they may hear language or see things that they don't see at home. Unfortunately it is part of a care setting that's very difficult to completely avoid.

DR. MAXWELL: So on balance, given those things that were to some extent inevitable, was it in the patient's best interest to be admitted?

A. No. Absolutely, it was a last resort. Nobody would ever want or should be admitted to hospital if they didn't have to be. That is the way forward and what people have been striving to. Unfortunately, there are people who will require hospital admission. But nobody should be in hospital that doesn't have to be there.

DR. MAXWELL: So what was it that meant that being in hospital, despite all these things, was in their best interest? Was it to protect other people, or...

A. Nowadays. If you go many years ago when people were put into institutions, this wasn't always the thought process. It has just been very difficult to get people out and discharged out of these institutions. It's been a very, very slow process. I would like to believe in this day and age, nobody now would be admitted to hospital if they weren't unwell and requiring treatment. Hopefully that is, going forward, the way it's going to be. But it's just been a very long process to discharge people who were admitted many years ago, maybe before these things were as well

thought about and as well known.

DR. MAXWELL: Thank you.

CHAIRPERSON: How long do you think you've got to go, Ms. Briggs?

MS. BRIGGS: 20 minutes perhaps. 12:38

CHAIRPERSON: How are you feeling? Would you rather get it done this morning or would you rather come back after a short break?

A. I don't mind. I honestly don't mind. Whatever suits everybody else. 12:38

CHAIRPERSON: Okay. There is no embarrassment about saying I need a break, I've had enough for a while.

A. No, I'm fine. I'm fine to go on. I'm just conscious everybody else may need a break.

CHAIRPERSON: You want to go on. Again, if at any 12:38 stage you start to flag, please do tell me and we'll stop.

125 Q. MS. BRIGGS: At your statement on page 27, paragraph 54, you talk about the dangers for staff at Muckamore, okay. It's something we've touched on already. You 12:38 say really that violence and aggression was part of the job?

A. Mm-hmm.

126 Q. You say that people expected to get assaulted daily, albeit obviously no serious injuries were sustained? 12:39

A. (Witness Nods).

127 Q. What could have been done to make Muckamore a safer place to work at?

A. I don't know. All those things that we know were not

ideal. People shouldn't be in hospital if they're not unwell. People shouldn't be in crowded environments. All those things would have made a difference, absolutely. On the day-to-day level of patient management, we did everything we thought we could to make things safer and to try and prevent aggressive behaviour.

128 Q. What support was given to staff who might have been assaulted?

A. Probably not enough. It became -- when you became assaulted so often, it became normal, I suppose. It was -- our tolerance was very different. In reflection now to what, you know, somebody coming newly into the job, you just took it for granted you were going to be assaulted. But you always had to be mindful that that wasn't normal and that somebody new would find that very difficult and they would have been supported at a peer level. But it was difficult, it happened daily and I don't know what could have been done to change that.

129 Q. You say at the end of that paragraph that you yourself were involved in using physical intervention when you were heavily pregnant.

A. Yeah.

130 Q. Should you have been in that position?

A. No, ideally not, but the incident that I recall happened very suddenly, it happened outside of the ward, it was within a reception area. Nobody knew it was going to happen. Nobody would have put me into

that situation had they realised that was going to happen. I suppose I did always have, and knew I always had, the ability to say no, I am not going to get involved in this but I had to weigh up the risks to the patient, to the people who were in the area who were not nurses and not trained to manage this, and to myself, and I made the decision. I don't know. It wasn't ideal, but --

131 Q. Had you been placed out of the ward and on to reception duties because of your pregnancy? 12:41

A. No, no, I was still working within the ward.

132 Q. Okay. Could you have been moved out of the ward?

A. Years ago, yes, you probably -- you would have been moved out of wards where you'd have got a lot of challenging and aggressive behaviour. But as time went on and the ward numbers reduced, all wards had challenging and aggressive behaviour so there was nowhere else really to go. You could have asked to have been moved, but again it was looking at the risks posed going to a new area, where you didn't know the patients and the environment, or staying with those that you knew, and often the behaviours could be predictable and you knew how to manage them. 12:41

133 Q. I want to go on to the part of your statement that addresses the use of CCTV in Muckamore, okay. It's paragraph 64 and through to 65. If we can go to paragraph 65 on page 33. You're discussing here what CCTV was about and why it was brought into Muckamore. You say in the second sentence initially that it was 12:42

accepted and agreed that CCTV was a safety mechanism to protect staff from allegations, and review patient incidents for safeguarding purposes. You say:

"We were told it would not be used for staff conduct issues." 12:42

Who told you that?

A. I don't know. On writing this statement, I've reflected a lot, particularly around that. I have no recall of any formal meetings or written information around the use of CCTV and all that came with it other than the policy. On reflection, I wonder should there have been more questions asked? But this generally was the feeling just amongst ward staff. 12:43 12:43

My time in Cranfield, the CCTV had already been installed and fitted so I presumed all those more official meetings and information sharing had already happened in the planning process and the actual installation. 12:43

134 Q. You go on to describe how staff were initially supportive of its use but once staff started to get suspended, staff became anxious and so on. How could CCTV have been better used at Muckamore? 12:43

A. I don't know, and to this day I still don't know. You know, CCTV absolutely is a protective mechanism and nobody can ever take away from that. I suppose it was the changes in the policy and the changes in its use,

the uncertainty over the criminal investigation, the lack of information around it; it has just become a massive area of unknown. Understandably, Muckamore had to put protective mechanisms into place after the abuse was discovered and things happened, but the constant changes in the protective mechanisms, such as contemporaneous viewing and all that came with that then made staff even more anxious. "Well, if they're doing this now and they said they wouldn't", and "They are doing this and they said they wouldn't"; things just keep changing and there was constant uncertainty.

CHAIRPERSON: And who was informing you, for instance, about contemporaneous viewing? Who would tell you that was happening, or was that just word of mouth?

A. Again, I think it was word of mouth. I don't recall formal meetings on reflection. Now, as a ward manager at the time and as a deputy, we absolutely would have been aware that there was contemporaneous viewing because you would have been contacted when anything was identified in your viewing, so you knew it was happening. But I don't recall official notification of when that was starting or why.

135 Q. MS. BRIGGS: You say in that paragraph that you were told multiple times by many people at Muckamore that there was no safeguarding threshold any more. Is that just based on what people had said to you, that's not something you had seen yourself, that there was no safeguarding threshold?

A. No, absolutely I seen it myself with regards to

safeguarding. Every single allegation, issue, question, anything, if you went out, you put it through safeguarding. Even if you knew and felt yourself it wasn't a safeguarding concern, it was reported through as safeguarding. You had no ability to make any decision-making yourself. Even at a ward manager level, everything had to go through to the DAPO, every allegation, regardless. Some of them were very unlikely, I suppose is maybe not the right word. You know, the patients we worked with would have made unsubstantiated allegations frequently. Somebody could have been off duty for a month and the patient would have said "They hit me yesterday." That had to go through your safeguarding, you'd no decision-making around it. It had to be notified to PSNI, it had to be notified to RQIA; there was never a discussion. If somebody made any comment that potentially, if you weren't certain, everything just got reported through. 12:46 12:46 12:46

136 Q. So when you say there was no threshold, do you mean no threshold through yourself reporting upwards? I'm thinking about at a higher level. 12:47

A. No. At a DAPO level, they also would have told me that it was out of their control. That was the common statement, there is no threshold; if anything gets reported through, it has to go through the whole process and full investigation. I don't believe they had control to --

DR. MAXWELL: So you are saying if an allegation was made against a member of staff and you could 12:47

demonstrate that they weren't on-site that day, it still progressed to a full --

A. Yeah.

DR. MAXWELL: -- safeguarding investigation?

A. Yes. 12:47

DR. MAXWELL: And was still referred to PSNI?

A. Yes.

DR. MAXWELL: So that must have been quite frustrating?

A. It was very frustrating for staff. You didn't even have to be on duty to become an alleged perpetrator. A protection plan would have been put into place for that person, even though they weren't on duty. So it was very, very frustrating. It made staff very, very anxious, because no matter, with the best will in the world and the best practice in the world, you were still going to potentially be victim to being an alleged perpetrator and safeguarding concerns. 12:47 12:48

DR. MAXWELL: So do you think that increased peoples' decision to leave?

A. Absolutely, yeah. You know, definitely. You thought every day I go into work here, I am at risk of becoming involved in a safeguarding investigation. You can't do that, you can't sustain that every day, you know, that constant risk, and then the fear of when this happens, is this going to impact my ability to get another job; do I need to get one now before it happens? It was never a question of if it happens, it was before it happened. Everybody felt they would at some point become victim to a safeguarding concern. 12:48 12:48

PROF. MURPHY: So did you raise that with senior staff, the whole issue of people feeling that they could never be sure that they wouldn't be --

A. Yeah.

PROF. MURPHY: -- a safeguarding incident. 12:49

A. I raised it within my original immediate line manager, so my senior nursing manager at 8A and I am going to say service manager - I don't know its official title. You know, it was raised with them but it was out of their control as well. These decisions had been made 12:49 that this is the process for Muckamore Abbey, for assurances due to what had happened. So, there was nobody certainly within my level of reporting and was aware of, that had any control over this. This just was the agreed process. 12:49

DR. MAXWELL: Were you ever told who had made that decision?

A. No.

137 Q. MS. BRIGGS: At the very end of your statement, paragraph 73, page 37 - and this is the last thing I'm 12:49 going to ask you about - you're talking here about the presence of senior management or Trust Board members on wards. You say this:

"As things became more and more destabilised at 12:50 Muckamore, managers would be less and less visible but usually appeared if a major incident had been reported or there was something on the news about Muckamore."

You say that you recall some senior managers coming to the wards often when there were further developments or announcements in criminal abuse investigations but you would not have seen them at other times.

12:50

So is what you're saying that really these people came on the wards whenever there was something to announce or there was some change in the status of Muckamore publicly that brought them onto the wards?

A. Yeah. So any time there was going to be -- they were aware there was going to be something on the news, they would have come in with, like, a draft statement, like a script, so that everyone was giving the same information. So if they knew that tonight it was going to come out that an allegation of abuse and they would expect potentially, you know, families, relatives or whoever it may be to ask questions and to call us, you were provided with a script that that was what you were to say if anyone asked you any questions. So they would have come around, told you to expect this and this is the script of what you should say if anyone asks you any questions.

12:51

12:51

12:51

DR. MAXWELL: Presumably quite helpful, because otherwise you wouldn't have known what to say to the family?

12:51

A. It was very anxiety provoking, I suppose, because then you are thinking, well, we are going to be on the news, what's it going to be? It was helpful to have a script because you would have had no other answers and nothing

else to say but it was also, I suppose, frustrating, because I don't know, you didn't know what you were talking about and you were being instructed just say this, and you were making reference to things that you knew nothing about.

DR. MAXWELL: Okay.

A. But you just had to say what you were being told to say.

DR. MAXWELL: So you were being asked to say things you didn't know whether they were accurate or not?

A. You had no information.

CHAIRPERSON: Did you ever get a script where you thought, well, that's not right?

A. Not me personally. I do remember a script being sent round and a lot of staff were uncomfortable with it and didn't share the information. I remember somebody contacting me at home, and they were a Band 5 - at the time I was Band 7, I think - and I said you know, I will support you to not speak that script because at a Band 5 level I don't think it's appropriate for you to even be involved in those discussions. There was no repercussion or consequence on that, they just didn't say anything.

CHAIRPERSON: They didn't repeat it?

A. Yeah.

DR. MAXWELL: You were the Band 7 ward manager, there was no discussion with you about what the statement should be, you were just told?

A. No. These things always happened suddenly, there was

no planning. It was just 'We have been made aware this is going to be on the news tonight' and things had to be put together and planned very quickly.

DR. MAXWELL: Nobody consulted you --

A. No because I was off. 12:53

DR. MAXWELL: -- about what the response should be?

A. No because I was off duty that day. It happened in a day.

138 Q. MS. BRIGGS: You've said there, and you say it in your statement, that these senior managers were there to let 12:53 you know that something's going to be on the news tonight. You say that they're saying that as opposed to checking in and seeing how staff were; that's what you've written in your statement. Earlier on in your statement, you do say you felt well supported at 12:53 Muckamore but then, when you read this, it looks a bit different.

Are you saying that you felt well supported amongst your peers at Muckamore but perhaps at that higher 12:53 level, you didn't feel that support?

A. Yeah, absolutely. You felt supported by your peers, by your ward manager. Going up to the next level of, you know, senior nurse manager, your 8A, I always felt supported. But it would have been after that level. 12:54 Now, again, you know, within management structures, the more senior the manager, the less direct involvement they would have had. But I wouldn't have felt much support, apart from I do make reference to a very

specific time and some very specific managers who came in and they were extremely supportive, but that was a short period of time.

MS. BRIGGS: Okay. That's all the questions I have, H330. The Panel might have some more. 12:54

CHAIRPERSON: No, I think we've asked all of our questions as we've gone along. So can I just thank you very much, first for making a statement, which has been very helpful, and also for giving us your time to give some very frank and useful evidence. Thank you very 12:54 much indeed.

THE WITNESS: No problem. Thank you

CHAIRPERSON: The timing is perfect. And we'll meet again at 2:10.

12:55

THE INQUIRY RESUMED AS FOLLOWS AFTER THE LUNCHEON ADJOURNMENT

CHAIRPERSON: Good afternoon.

MS. TANG: Good afternoon, Chair, good afternoon, 14:04 Panel. This afternoon the Inquiry will hear the evidence of Dr. Maria O'Kane, and that's as part of the consideration of evidence of either MAH staff or former staff. The internal page reference for her statement is 254. I should say that there are no documents 14:04 produced with Dr. O'Kane's statement.

CHAIRPERSON: Thank you. Let's get the witness in.

MS. TANG: Yes, thank you.

DR. MARIA O'KANE, HAVING BEEN SWORN, GAVE EVIDENCE TO THE INQUIRY AS FOLLOWS:

CHAIRPERSON: Dr. O'Kane, welcome to the Inquiry. Thank you very much for your statement. Thank you for giving up your afternoon to come and assist us. I'll hang you over to Ms. Tang. 14:05

139 Q. MS. TANG: Hello again, Dr. O'Kane. We met a short time ago.

14:05

I am going to be taking you through your evidence this afternoon. The first thing I would like to do is to check with you that you're content to adopt your statement as your evidence to the Inquiry?

A. Yes. I think the only discrepancy that I've noticed in it is between points 14 and 25. I think 14 probably isn't as clearly labelled as it needed to be. 14:05

140 Q. Paragraph 14; is that correct?

A. Yes. I think I suggest in that that when I saw the CCTV, I was an associate medical director. The correct interpretation of that is in number 25, where I was actually divisional medical director. 14:06

141 Q. Okay. And those are different roles?

A. They were different roles, yeah, but I've mixed them up. 14:06

CHAIRPERSON: So in paragraph 14, do we replace "associate" with "divisional"?

A. Yes. And I think the... Let me see.

CHAIRPERSON: It's at the top of page 6.

A. Yes. So in number 14, I have written there that I saw the footage in 2017 in my role as associate medical director. What's more correct is what I've said in paragraph 25, which is I viewed it in 2018 in my role as divisional medical director. 14:06

CHAIRPERSON: Oh, I see. Right, thank you.

DR. MAXWELL: So you're saying you didn't view it in 2017?

A. No. I think it was 2018.

CHAIRPERSON: Right, thank you. 14:07

142 Q. MS. TANG: Thank you for that. Are there any other things that you want us to be aware of in your statement?

A. No. That was the only one that I think wasn't clear.

143 Q. Okay. So subject to that observation by you, are you content to adopt your statement otherwise as your evidence? 14:07

A. Yes. Thank you.

144 Q. Thank you. Dr. O'Kane, I'm not going to read through your statement because it has already been published on the Inquiry's website, but what I will do is confirm that we have -- 14:07

CHAIRPERSON: No, it isn't.

MS. TANG: Oh, I am sorry, has it not?

CHAIRPERSON: No. These are staff statements and they are not published on the website. 14:07

MS. TANG: My apologies. Chair, would you like me to read the statement into evidence?

CHAIRPERSON: No, we don't intend to read the statement

but certainly précis it with the witness.

MS. TANG: Thank you. I can do that.

145 Q. Dr. O'Kane, I should say to you that there have been some ciphers applied to your statement, so I won't be mentioning the names of MAH-based staff in the course of that. 14:08

You tell us in your statement that you graduated from medicine in 1990 and then trained as a psychiatrist, and that you were appointed to your first consultant post in 1999? 14:08

A. (Witness Nods).

146 Q. You went on then to take some management roles as a clinician from 2010 onwards within the Belfast Health and Social Care Trust, and then you were appointed as Medical Director in Southern Trust in 2018? 14:08

A. (Witness Nods).

147 Q. Thereafter you became the Chief Executive in May 2022, and that's your current post?

A. Yes. 14:08

148 Q. Okay, thank you. If I can look at paragraph 3 of your statement, which should be coming up on screen. There it is. I just wanted to ask you in relation to that, what is the difference in the role between the medical director and the associate medical director? 14:08

A. At the time I was associate medical director in the Belfast Trust, we had four clinical associate medical directors for approximately 1400 doctors across the Trust. So, my role at that time was as associate

medical director for the Adult Social and Primary Care Directorate. Within that, I had responsibility for the doctors who worked in mental health, learning disability, and older peoples services. Then my colleagues who were employed in a similar role had responsibility for different aspects of medicine, surgery, primary care, and anaesthetics. 14:09

So in that role, essentially I had a medical leadership role. I managed, professionally managed, the doctors who worked within my directorate. They were psychiatrists and geriatricians primarily and some GPs. Then the focus of the work was certainly in terms of professional issues in relation to appraisal, revalidation, job planning, the trainees as they came through that system, and then working corporately with the other associate medical directors in terms of providing support to the medical director within the Trust. 14:09 14:10

So when I started in that role, Dr. Stevens was obviously the medical director. We would have met on a weekly basis, and there would have been professional medical issues discussed. So again, that would have been about policies and processes that were specific to medicine that would have come from the universities, the GMC, the regional training body, or other areas specific to medical policy and process within the Belfast Trust. Part of my role then was to translate 14:10 14:10

that into the directorate that I was associate medical director for, at the same time then as to medically manage the doctors who were within that directorate.

DR. MAXWELL: Can I just clarify that? So you are attached to a directorate? 14:11

A. Yes.

DR. MAXWELL: So there were four associate medical directors, each attached to a different directorate; is that correct?

A. Yes. 14:11

DR. MAXWELL: So the directorate structure usually has a unitary leadership team, sometimes called a collective leadership team, with a business manager, a directorate nurse and a directorate medical director. Was that the scheme that was working at the time? 14:11

A. No. That scheme didn't come into the Belfast Trust until 2018/2019, at which point then the job that I was undertaking as associate medical director was divided in three. So I became the chair of division, or the divisional medical director, for adult psychiatry and 14:12 adolescent psychiatry. There was a chair of division for learning disability, and another chair of division then for older peoples services. So, my original post was split into three posts.

DR. MAXWELL: So there wasn't a medical director for 14:12 the directorate?

A. Only insofar as you were a conduit for the medical director in terms of professional medical practice back and forth, but not in the way that the structure would

exist now and probably exists. I think it's very common in England, increasingly common in Northern Ireland, where you would have a chair of division structure in the Belfast Trust -- you know, it would have been in the Belfast Trust before I left it. Again, you were more in the role of medical director then at that point.

DR. MAXWELL: So at this time when you were associate medical director, you didn't have any collective responsibility for the running of the directorate as a whole? 14:12 14:13

A. Not specifically. The focus was on professional medical issues. Again, strategically, you know, I would have been involved in setting, you know, a strategic vision in relation to how medicine would be brought in alongside all of that, but in terms of operational responsibility or a collective responsibility for the professions within the directorate, that wasn't the structure at that time. 14:13

DR. MAXWELL: So what was the associate medical director's responsibility for clinical governance? 14:13

A. It's not specifically described in the job description. So again, it would have been tied up with the professional governance of medical staff. So if there were concerns about any issues of professional practice that were raised along the medical lines, I would have had responsibility for that. I would have had responsibility for any concerns in relation to trainees or, you know, any difficulties to do with the training. 14:13

It was in relation to that rather than in the way we would have chairs of divisions or divisional medical directors these days, where actually a huge emphasis would be on governance.

DR. MAXWELL: So who was responsible for clinical governance in the directorate at that time? 14:14

A. There was a clinical and social care governance lead, and at that time the lead for that was (H287).

DR. MAXWELL: That was who, sorry?

A. (H287). 14:14

DR. MAXWELL: Okay, thank you.

MS. TANG: Chair, the individual that has just been mentioned has a cipher.

CHAIRPERSON: Really?

MS. RICHARDSON: Yeah, in the statement it has. 14:15

CHAIRPERSON: I'm quite surprised because the seniority, they're not a member of staff, as it were. Have we used that individual's name before or is it a new cipher? Okay, I'll retain the cipher for the moment, but that may well have to be lifted. Can we sort that out on the feed. 14:15

MS. TANG: Can I just clarify with you, Dr. O'Kane, whenever you mention being associate medical director, you talked about the post being split into three. At what point was the post split into three? 14:15

A. It was split into three towards the end of 2017/the beginning of 2018.

149 Q. Okay. So do I understand correctly that when you came into that post in 2010 --

A. Yes.

150 Q. -- so you were covering all of these areas up until 2017 or so?

A. Yes.

151 Q. Yes, okay. Can I ask, in terms of the amount of your time that you had to spend on that, how was your week divided up as a clinician at that stage? 14:16

A. So, at that point in time -- and my job then changed in 2015 when I became one of the deputy medical directors in the Belfast Trust for workforce and education in that I had a reduction, a slight reduction, in the associate medical director sessions and a slight reduction in the orientation of the clinical work at that point in time to try and accommodate that. So when I started on 1st September 2010 as associate medical director, I had five PAs per weeks, so that would have been 20 hours per week. When it came into 2015, the job was further changed in that I think between being deputy medical director for workforce and education and being associate medical director, the total time to that given was 24 hours per week, I think, or slightly more. 14:16 14:17 14:17

152 Q. So, in or around six PAs at that point?

A. Yeah.

153 Q. So you were still practising as a consultant psychiatrist throughout that period? 14:17

A. Yes, and I was still fulfilling my SPA commitments. So within the consultant job description, out of the total allocation of time given in the week, there was a

mandatory 1.5 or six hours per week that had to be given over to training and development, and some of that overlapped with the managerial role and some of it overlapped with the clinical role. So that again was an area that had to be defined within all of that. 14:18

154 Q. Okay. I've slightly jumped ahead with that question and I want to touch on one thing before that in terms of your development as a psychiatrist. You mentioned in paragraph 5 that you were a junior doctor at MAH in 1994. 14:18

A. Yes.

155 Q. And that prior to that, you'd had really very little exposure to learning disability; would that be fair?

A. Yes. I think I mentioned in the statement that we had a day's training on learning disability as medical 14:18 students but most of it -- all of it at that point then was on the job.

156 Q. Whenever you went to Muckamore, had you chosen to go there to get a bit of learning disability experience or was that just the way the rotation was organised? 14:18

A. It was offered as part of the rotation, but I felt very fortunate to get it because not everybody did, because in those days you were offered either learning disability or child psychiatry, and I was given both at various stages. Again, because learning 14:19 disability/psychiatry is about developmental psychiatry, I thought that was really helpful because, you know, laterally I trained as a general adult psychiatrist but also as a psychotherapist, and in

terms of understanding development, the learning disability component of that was really important.

157 Q. Was it your experience that your junior doctor colleagues at the same time were quite interested in learning disability, or would you have said it was a bit of a niche area that a lot of them didn't consider? 14:19

A. There were probably -- it was probably a variety. I mean, I've always considered that learning disability is quite a hard area to work in. I think, you know, people will always come to psychiatry with different interests, and I think some of it -- I mean, just very vaguely, I think, you know, some of us found it more interesting than others, I think. But other than that, I couldn't say anything very much more specific than that. 14:20

158 Q. Okay. Thank you. I want to then come back to your role as associate medical director, which you've told us about, and the coverage of that role. So thinking about 2010 until 2017 when the role was divided into three, and you've mentioned that you had around five sessions a week that you could put into that, what hospital sites did you have to cover the doctors on? 14:20

A. So when I was associate medical director, I covered Muckamore, Iveagh, which was the children's part of learning disability services, Beachcroft, which is the regional child and adolescent mental health unit, the Mater, Windsor House, and Knockbracken Healthcare Park, plus the community sites. The Belfast Trust provides mental health services into the South Eastern Trust, so 14:20

particularly in relation to child and adolescent mental health forensic services, and, again, part of the remit on the Knockbracken site was Shannon clinic, which is the regional forensic service. Also then for the South Eastern Trust, we provided learning disability services. Then in addition to all of that, we provided regional brain injury services, regional eating disorder services, and at a point in time I provided regional personality disorder services. 14:21

So the Belfast Trust is quite unique among the Trusts in Northern Ireland in that it provides for the local community in the Belfast area. It also then has some generic provision in relation to the South Eastern Trust, but also then provides all of the regional services. 14:22

159 Q. So would be it fair to say that's a very broad remit across a large number of sites?

A. Yes, and that was the psychiatry component of it. There was also the older peoples component of it. 14:22

160 Q. So all of the other sites that older people services were delivered on.

A. Yes. So for those I covered the Mater, the City, the Royal, and Musgrave Park, and the community.

161 Q. So in five sessions a week, that sounds like quite a challenge? 14:22

A. It was, yeah. Yeah, yeah.

162 Q. When you think back on that, do you feel that you were able to visit Muckamore and to spend time there, or how

much contact would you have had with Muckamore at that point in time?

A. I would have visited it but in a relatively infrequent basis. So I couldn't tell you the absolute frequency of it. Obviously I had been familiar with the site from when I was an SHO, although in 1994, although it was greatly changed in the interim because, you know, the buildings had been developed. But I certainly wouldn't have been there as frequently as every month. It probably was every, you know, every quarter. 14:22 14:23

163 Q. When you did go to the Muckamore site, was it for a particular meeting or was it just as an informal catch-up with your medical colleagues on-site?

A. It was usually -- one of the things I set up whenever I started as associate medical director was a Trust-wide mental health meeting on a Friday morning. Actually, that was to bring -- because, you know, one of the things that had happened in 2007 was that there were five Trusts brought together under the banner of the Belfast Trust, and the mental health services and learning disability services were scattered throughout that, right. Again, I think part of the focus then was to try and consolidate all of that. 14:23 14:23

So, in 2008/2009, what I had been working on with the previous associate medical director was galvanising all of that. So we would have had the learning disability consultants on the Musgrave Park site along with all of the other psychiatrists on a Friday morning. So a lot 14:24

of the business in relation to meeting with the consultants and the juniors in psychiatry was done on a Friday morning when we were altogether on the one site, and it was to try and be as efficient as possible.

So any time then that I was on the Muckamore Abbey site, it was specifically to -- occasionally, because I also was a clinician, I would have been asked to give second opinions in relation to -- sometimes in relation to mental health legislation but very often in relation to personality disorder, because that was my clinical specialty, or second opinions in relation to other aspects. So I would have been on the site for that reason, specifically to see a patient and the clinical staff and/or the family. Then the other times, it would have been there for meetings with the clinicians; for example to attend the Muckamore Abbey mental staff meeting or something specifically to do with the junior doctors. But it wouldn't have been much more frequently than I've described but I would have been there for a very specific reason. 14:24 14:24 14:25 14:25

164 Q. Okay. The Friday meeting that you refer to, is that the same one that you mention in paragraph 19? I wonder if we could just call that up, please.

A. Yes. 14:25

165 Q. It sounds like it may be.

A. Yes.

166 Q. Okay.

A. That's it.

167 Q. So, whenever you were going to meet with your consultant colleagues on the Muckamore site, as you've described you would have done, would those have been occasions where, if they'd had any concerns, say, about staffing levels or complaints or whatever, might they have raised those with you? 14:25

A. I think most - I mean, I'm working from memory at this point - I think most of those meetings were around, very often, concerns about just how few junior doctors they had because that was an ongoing challenge. In the course of all of that, what we also had to do, particularly when we brought CAMS services in underneath the associate medical director, and that happened in October 2010, was about the amalgamation of the rota. So I would have been up to, you know, discuss all of that with them at a point in time because we completely reconfigured the out-of-hours rota to make sure that Muckamore was covered at nights and weekends, along with the GPs from Randalstown, but also to think about, you know, the inductions that needed to be done for those medical staff to come on-site, and for then the Muckamore staff then to cover into Beachcroft or other areas of the Trust at night if they hadn't been used working there previously. 14:26 14:26 14:26

So, some of the meetings were around that and then about the monitoring of all of that to make sure that that was in place. Then, in addition to that, to talk about, you know, changes in clinical provisions. So 14:26

if, you know, someone within the group retired or moved on or changed, the consultant and SAS group, I would meet with them then to think about how clinically we could change services to actually accommodate that, what needed to be done in terms of, you know, interviewing for new staff, new medical staff, and to think about any other opportunities that were there.

Then, laterally, before I left that role and became chair of division for mental health services, some of the meetings would have been around the area of negotiation in relation to releasing, I think it was two or three consultant psychiatrists from the Muckamore Abbey site, to work specifically and be employed by the Northern Trust site and to provide cover onto the Muckamore Abbey site at night. So again, the vast majority of the discussions were very much about medical issues. 14:27 14:27

What would have come through strongly at various points were, I think, consultants' frustration about the slowness of discharge. It was a constant theme throughout those years about the lack of funding that there was in the system for specialist clinical placements, and how demoralising that was for the patients and the families and for them. Also at various points in time, you know, some concern about staffing, but mostly it was about medical staffing and the shortage of medical staffing. 14:28 14:28

168 Q. You made reference to the fact that there were concerns at times that there were very few juniors?

A. Yes.

169 Q. Can you recall why there were so few juniors? What were the factors that had brought that about? 14:28

A. I think changes in working practice. Now, traditionally Queen's has been a high supplier of trainees into the psychiatry training scheme. At one point, we led the UK in terms of recruitment. I think as rotas expanded and psychiatry became more 14:29 specialised, the demands on junior training places got more and more stretched. Also, when general practice became increasingly more specialised and tied to the three-year registrar scheme, I think that really limited the number of GP trainees who came through 14:29 mental health services overall, but particularly learning disability.

So, that started to impact. Also then because at times we were short of consultant psychiatrists, it meant 14:29 that there were fewer recognised training slots for juniors because the college is understandably really strict about who can train and who can't. Again, if we had a long-term locum in one of those positions, for example, who couldn't take trainees, that then limited 14:29 the numbers as well. So it was due to numerous factors.

Also I think because, you know, the demography of

medicine has changed, so there were more female trainees. You know, all of us who came through at various stages probably took maternity leave and that automatically then has an impact on service provision. But in terms of then the backfill of clinicians to fill those posts, that was a lot more limited across the piece than it should have been.

The other thing is regionally, and I think every specialty is suffering from this now, is, you know, the regional planning for the filling of posts was constantly trying to keep up with the demand, and that made this extremely challenging. 14:30 14:30

170 Q. Okay. In terms of the practical impact of not enough juniors, did that just push the work back up to the consultant staff in terms of covering on-call, or how did that play out in practice? 14:30

A. I think certainly in terms of some of the day-to-day work, there was cover by and large for the site because there were associate specialists who were there, and that was helpful. It did mean that there was a more onerous workload in particular, I think, for the consultants particularly in the community clinics, because then they found that they were having to run the community clinics themselves without juniors and that really added to their workload. Bearing in mind that certainly within medicine the vast majority of learning disability work takes place in the community, you know, that was onerous. Particularly as well given 14:31 14:31

that they were so spread out across the Belfast Health and Social Care Trust areas, and at one point the Northern Trust, they were covering a vast area.

171 Q. I want to ask you now about if there had been a complaint or a concern raised, perhaps by another member of staff, or indeed a patient or a family member, about a doctor, would that have been brought to you or would that have gone somewhere else? 14:31

A. No, that would have been brought to my attention primarily through the clinical director. But yes, that would have been raised with me, yes. 14:32

172 Q. If there had been a complaint or a concern raised about the standard of care generally, perhaps the way patients were being treated, would that have come to you or might that have gone elsewhere? 14:32

A. It was usually -- I mean, all of that was usually dealt with through professional lines. So, I mean, if there were concerns about, for example, the prescribing of medication or, you know, use of the mental health legislation, or anything to do with diagnosis again, and there had been a complaint made about a doctor or a doctor's performance or their working, you know, patterns, that would have been brought to my attention. If it was something a bit more abstract in relation to medicine but obviously very important to the patient and, you know, a complaint had been raised in relation to nursing or social care or AHP care, that tended to be dealt with in those domains and I may or may not have heard about it. 14:32 14:33

173 Q. Okay. Thinking about paragraph 15 particularly, if that could be brought up on screen, please. This is just again talking about your general coverage of your role as associate medical director. You have mentioned at a later stage that you were asked to view CCTV footage.

A. Yes.

174 Q. Now, I'm not asking you to name anyone - I'd ask you that you don't, please, in your response - but were you aware of any medical staff identified on the CCTV footage? If you were, how was that managed?

A. In terms of the two parts of CCTV footage that I saw, there were no medical staff involved. The reason - and I think that's the point I was making in point 25 - the reason I was asked to view it at that point in time was because I'd obviously, you know, had worked that area until I became chair of division for mental health services, which was adult and child and adolescent mental health psychiatry. I was asked at that time, along with another very senior nurse, to view this footage just for my reflections in terms of, you know, what I saw. But certainly having seen the footage at that point in time, I didn't see, or I didn't have any concerns about medical staff being involved at that time.

DR. MAXWELL: Can I ask you, we've heard a lot about the historic abuse viewing team. So, there was a six-month period from March to October, I think, of 2017, there were a team of social workers primarily

viewing it. Were you ever informed that the historical viewing had identified members of the medical staff?

A. No, I wouldn't. Because if it was 2017, I would have been associate medical director at that point.

DR. MAXWELL: But they weren't looking at it in 2017, they were looking at it during the time you were chair of the mental health division, but they were looking retrospectively at CCTV footage from 2017. 14:35

A. When I was chair of division for mental health, there were three chairs. So there was a chair of division for learning disability, a chair of division for mental health and a chair of division for older peoples services. Once we moved into those chair roles, our focus was into each of those divisions. So I wouldn't have been aware of what was going on within learning disability at that point in time. 14:35 14:36

DR. MAXWELL: So you were never made aware of any doctors being identified on the historic footage?

A. No, not specifically that I can remember at that time.

DR. MAXWELL: Would you have expected the chair of the learning disability division to have been made aware? 14:36

A. If they were -- yes, I mean, if it was within their directorate, you know, you would have hoped they would have been.

DR. MAXWELL: You would expect? 14:36

A. Yeah.

DR. MAXWELL: Okay.

A. But again I know that, you know, after I saw the original, the footage at the beginning, I mean,

obviously that created a huge amount of concern within the Trust, you know, concern about the patients. Again, I think because there were adult safeguarding concerns in the midst of all of that, that was dealt with very confidentially at that point in time, so I wouldn't have automatically been aware of what was going on. I don't know whether the same would have been applied then to the chair of division for learning disability at that time or not. I can't, I can't say. 14:37

DR. MAXWELL: But you do say in paragraph 25 that in 2018 in your role of chair of division for mental health, you were contacted and asked to look at CCTV. So, if you were chair of mental health rather than learning disability, why had they asked you and not the chair of learning disabilities to look at the CCTV? 14:37

A. I think because it was for -- I mean, my sense at that stage was it was for independence because one of the other -- I mean, the senior nurse that I viewed it with was from outside learning disability as well. We both looked at it at that point in time. But I think it was to give some degree of independence. 14:37

DR. MAXWELL: Can I just clarify a point here on paragraph 28? You say you alerted your concerns, and you say to Dr. Tony Stevens, medical director. Was he the medical director in 2018? (Short pause) Maybe you can come back to us later, but I'm just wondering if he had left by then. 14:38

A. I don't actually know.

DR. MAXWELL: Perhaps you can come back to us.

A. I can't remember which date actually Dr. Stevens moved. But... but I was fairly -- and again, you know, I'm working off my memory. I know I definitely spoke to Marie Heaney and to, you know, the director for ASPCD and director of nursing. No, I'll check that, yeah. 14:39

DR. MAXWELL: Okay. Thank you.

175 Q. MS. TANG: I want to go to paragraph 18, please. Paragraph 18 refers to restrictive practices. I wanted to ask you that apart from at Muckamore itself, which other hospitals would have applied restrictive 14:39 practices and what form would they have taken?

A. Now, across mental health and learning disability services, there would have been MAPA used at times whenever -- you know, in extreme circumstances whenever patients required containment. So at that point in 14:39 time, it would have been across the Mater, Knockbracken Healthcare Park and Windsor and Beachcroft and Iveagh, the children's unit, basically it would have been using MAPA to contain. So didn't happen in the community, obviously. But no, within each of those settings, 14:40 yeah.

176 Q. You mentioned in paragraph 19 the Friday meetings. I wondered whether or not things like the use of seclusion or restrictive practices would have been things that were discussed in those Friday clinical 14:40 meetings that we discussed earlier?

A. It wouldn't have featured highly in it. You know, I think, mostly, unless it was specifically to illustrate a point around something. So what would have got

discussed was, you know, patients' diagnosis, treatment; what the differentials would be; any conundrums that there were around actually deciding, you know, what was the best way of understanding this particular patient and taking forward their treatment regime. Then there would have been discussion around the nuances of mental health legislation.

But there may, you know, in passing have been comments made about, you know, about the patient being very agitated, that they could tell that they were becoming less agitated because, you know, they required, you know, less containment or less use of seclusion. But other than that, it wouldn't have featured any more prominently than that. 14:41

177 Q. Yes, okay. Can we go down to paragraph 22 now, please? You make reference there to a media report in relation to an allegation of abuse and the trial of a nurse from the Ennis Ward, and that was in around 2015/2016. Was that the first time that you had heard of any such allegations? 14:42

A. Yes, and that was retrospectively. I think it came to my attention because I had noticed it in the newspaper, as I think I've said there. Again, I think because it was in relation to a nurse. It hadn't been discussed medically, though. And I do remember there were conversations after that point in time; I think it was about the point that the nurse was charged. 14:42

178 Q. Did it surprise you that you only heard about that via

the media, given that it was a relatively small hospital site?

A. I mean, in -- yes, when I think about it, you know, when I thought about it when I was putting together this statement, yes. Yeah. 14:42

179 Q. Is it something that you were surprised, when you look back on it, that your consultant colleagues on the MAH site didn't alert you to?

A. And I am not sure how -- I know that I had, you know, I had discussions with some of the senior team in relation to that. I'm not sure how widely it would have been known because, again, if it was within one ward, it may well have been that it was known within that ward but maybe not some of the others so clearly. 14:43

DR. MAXWELL: What sort of governance arrangements would you have expected to escalate that so that you would have known of a significant event? Because you have already said you weren't involved in clinical governance. How would you expect to have been alerted to this? 14:43

A. Well, I can tell you what I would expect now, which is probably more straightforward, right, and that's essentially, you know, the way that governance is approached within the Trust these days is very different. I think, you know, within mental health and disability, there will be very regular governance meetings that will involve all the professional leads. You know, something like that would be escalated, you know, as far as the Chief Executive these days and we 14:43

would be very clear about -- in the context of this, I think these days we would be clear that we would take a step back, you know, triangulate any of that information, try and understand if there were any other risk points or anything else to be understood. 14:44

So I think all of that has moved on in Northern Ireland quite a lot in the last few years. But I think at that point in time, I think it would have been dealt with as an isolated incident. 14:44

DR. MAXWELL: So we have heard from other witnesses that at Muckamore there was a risk and governance meeting, and we have heard that the clinical director attended. Were you aware, either as associate medical director or as chair of the mental health division, how 14:44 these local risk and governance committees would escalate things of concern?

A. I mean, my sense would have been it would have been escalated up through the lead for governance. Again, if there was a query in relation to medical practice in 14:45 relation to that, then it would have been escalated to me.

DR. MAXWELL: I suppose what I'm getting at is that we have seen lots of organisational charts of various years in Belfast Trust. Certainly, experience in other 14:45 jurisdictions is that you don't have standalone committees, they are subcommittees of a subcommittee until you get to Board level.

A. Mm-hmm.

DR. MAXWELL: Were you aware in the directorate of a risk meeting or a governance meeting which was fed by the committees of the individual sites?

A. Yes, I mean, those -- there would have been mention of those that would have -- now, bearing in mind it was a vast directorate, right. 14:45

DR. MAXWELL: Yes.

A. And the governance meeting, the overall directorate meetings would have happened once a week or once a fortnight, depending on other interrupting business. I mean, it was a vast directorate, you know, covering many bases. So the details of the local meetings would not have come through clearly, I think, in relation to all of that. But again in relation to the escalation, I mean, I would have expected that it would have come up through that system because it should have been of interest to all of us, but I specifically wouldn't have known about it because it wasn't medicine. If it involved a doctor, I think I definitely would have been told. 14:46 14:46

DR. MAXWELL: So you didn't sit on the directorate governance meeting? You didn't attend the directorate governance meeting?

A. Not on a -- I would have gone if I was invited, but I wasn't there on a regular basis. 14:46

DR. MAXWELL: And did you attend the directorate meeting, so general business weekly meeting?

A. Yes.

DR. MAXWELL: You did attend that?

A. I did attend that, yes.

DR. MAXWELL: So as far as you remember, this incident on Ennis Ward that resulted in a prosecution didn't get brought to the directorate weekly meeting; wasn't escalated to that meeting, as far as you remember? 14:47

A. Not as far as I remember but I am working off my memory.

DR. MAXWELL: No, I appreciate that.

A. Again, you know, I contrast that to what would happen today where I would imagine, you know, that would 14:47 definitely be front and centre.

DR. MAXWELL: I appreciate that. We have heard other witnesses say that staffing was repeatedly raised and put on the hospital risk register. Was that the sort of thing that you would have expected to have been 14:47 escalated to the directorate weekly meeting if it was on the hospital risk register, or was that something that would not be covered at that meeting?

A. Again, I think it would have -- it would have been mentioned at times in relation to what the concerns 14:48 were. But, from my memory, a lot of the focus was on the discharge of patients and the retraction of the Muckamore Abbey site. But there certainly would have been discussion at times about needing additional staffing because of, you know, numbers of patients or 14:48 patients who had delayed discharges and some of the patients who had become unwell or, you know, were particularly challenged at a point in time. But again, not specifically. But, you know...

DR. MAXWELL: If something did get to the directorate meeting, what would have been the criteria for the directorate to escalate it to the next level?

A. Now, from my experience of all of that, that obviously would have come into it -- now, I wasn't, you know, a director in the Belfast Trust but certainly from my experience of working with the various directors who moved through that, again that, I presume, would have been brought to their executive team meeting - you know, they met every week - and then would have escalated beyond that. 14:49 14:49

But again, you know, the business of Trusts in Northern Ireland looks a bit different from the business of Trusts in England, where there are separate mental health Trusts and very often involves learning disability, compared with here, where, again, a lot of the executive committee business into Trust Board is dominated by the acute medicine and acute surgery agenda. And I think -- and I mean, that's really challenging, I think, for all of us in that context. 14:49 14:49

When I compare, for instance, the minutes of Trust Boards in Northern Ireland compared with the mental health Trust Boards in England, they are like night and day, they are very different in terms of what gets described. So, I think that -- I don't know if this was discussed at an executive meeting in the Belfast Trust at that point in time. I don't know. I would 14:50

presume it was.

But in terms of the escalation of that, I think it was -- because it had such a vast agenda, I imagine, you know, getting a mental health and disability representation there at times was very difficult.

DR. MAXWELL: I appreciate it's a vast Trust with, you know, multiple specialties, and even within Northern Ireland it's a very complex Trust.

A. Yeah. 14:50

DR. MAXWELL: Is there, or was there at your time, a senior management team where senior representatives of all the directorates met with the executive team?

A. No. Once a year we would have met with -- the senior leaders within the adult social and primary care directorate would have met with the Chief Executive. Again, mostly that was to -- we would have brought the consultants along to that across the directorate. Again, most of that was to concentrate on medical issues. So, that's we would have talked about, in relation -- and the Chief Executive would have brought, from memory, would have brought the director of nursing, director of medicine social work with him to that meeting, and others. But the focus of that was, I think, to highlight medical issues to the Chief Executive. So, if there were opportunities for development or we had particular concerns about staff shortages in various areas, those would have been highlighted very much. Then, if we had particular

concerns around patient care, and a lot of it was to do with the paucity of services in mental health and disability and also the enormous demand on older peoples services, that's what would have got discussed, right. 14:52

I think, you know, the lack of funding for mental health and disability in Northern Ireland is endemic. We sit with a budget that is half the equivalent of the rest of the UK, because we sit at 6% compared with 12 14:52 to 13% across the rest of the UK. So again, it was a constant mantra in the system just how underfunded all of this was. But in terms of -- unless it was something very specifically to do with medicine at that time those annual meetings, it would have been unlikely 14:52 that we would have talked at great length about any of the other specialties or any of the other disciplines, yeah.

DR. MAXWELL: Okay, thank you.

PROFESSOR MURPHY: It sounds to me from what you are 14:53 saying as though doctors and nurses rather worked in silos. Would that be an unfair description?

A. I think that wasn't consistently the way across the piece, right. But I think in mental health services, I think it was more integrated than it was in learning 14:53 disability services. I think that was primarily driven by the fact that Muckamore was primarily, you know -- I mean, the medical staff, because they were off site doing clinics a lot of the time and the trainees were

off site doing clinics and training, you never got the sense there was a very heavy medical presence there. Unlike the community clinics, where those were almost exclusively run by the medical staff with, you know, contact with the learning disability community nurses, psychology and, you know, speech and language therapists, for example, and there would have been multidisciplinary team meetings.

But in the way I would have been used, I think, functioning in mental health, where, you know, I would have worked in a very integrated team and I would have seen that, you know, with some of the others, it just wasn't the same feel to it. 14:54

PROF. MURPHY: So when you found this out in 2015/16, did it stop you feeling confident that good care was taking place at Muckamore? 14:54

A. On the face of it, it seemed to be -- there were always, I'm sure -- mental health and disability, as you'll know - and I get to see it now in relation to the rest of the Trust - carries a significant burden of incidence, you know, in terms of violence and aggression and all of those, and a lot of that is tied up with mental ill health. So I think that Muckamore and mental health services across the piece were always used to that level of functioning. It wasn't always commented on. Certainly now that I have oversight of an entire Trust and I see the comparison, I can see just, you know, the balance in all of that. 14:54 14:55

In terms of the level of disruption across learning disability and mental health, you know, we will have three times the level of incident there than we might have in the other hard to -- you know, the other area that's a quite challenged, which is the Emergency Department, right. And again, it was the same; my experience was it was not dissimilar in Belfast. And I think that, you know, that has always been the backdrop to this. 14:55

And I think then for someone to be convicted in the midst of all of that certainly stood out. But again, I think the tolerance for all of that, I think, across mental health and disability has always been -- has always had to be higher than it has been in the rest of the system. I'm not saying that as an excuse but just an observation. 14:56

PROF. MURPHY: I mean a tolerance of incidents occurring is one thing; a tolerance for staff behaviour of that kind is quite another, I would say. 14:56

A. Yes. And I wasn't even thinking about tolerance of poor behaviour, I was thinking just tolerance of the level of disruptive incidents. Yeah, yeah.

CHAIRPERSON: Can I just ask, what you've said in this paragraph was that you understood that the incident had been escalated through the relevant nursing management lines? 14:56

A. Yes.

CHAIRPERSON: I think you were asked this before: Were you still surprised that the first time you heard about this - which was a criminal trial -

A. Yes.

CHAIRPERSON: - was through the media? Did that actually surprise you, that it hadn't come to you via some other route in the Trust? 14:57

A. Again, I would have compared it with mental health services or geriatric medicine services, and I think it was surprising that I hadn't heard about it before that. Again because I worked in mental health services, I would have been very aware of a lot of the things that were going on just in my day-to-day work. This did rather stand out. But it didn't... Yes, I think I was surprised. 14:57 14:58

CHAIRPERSON: So how would you have expected to have heard about it through appropriate channels? How should it have got to you?

A. Well, again, it's probably best -- it's probably best to think about how I would hope it would happen today, which would be that it would come up through, you know - well, as Chief Executive I would expect to know. But also, it would come up through ordinary governance channels in relation to weekly governance and then all of the adult safeguarding and, you know, governance conversations and supports that would be put in around that. 14:58 14:58

CHAIRPERSON: But should it not also have happened then?

A. I think in retrospect it should have happened then, yes. Yes.

DR. MAXWELL: Except that you've already said that you weren't part of the governance structure and we wouldn't be telling everybody confidential information, it would have come through those who were part of governance structures. You've said that you weren't part of the collective leadership team for the directorate, and you weren't responsible for clinical governance. So even if there was a good system, how would it have got to you? 14:58 14:59

A. I would have thought -- I mean, it was a fairly remarkable event, right, and I would presume that there would have been some discussion about it in-depth, right? But, you know, the formal structures for supporting that weren't as clear then as they would be now. 14:59

DR. MAXWELL: So at that time, given that you didn't go to the governance meetings and you aren't part of the collective leadership team, where do you think that discussion would have taken place? Or are you saying that the associate medical director should have been part of the governance system? 14:59

A. In retrospect now, I can see how it would have strengthened that system quite a bit to have had the associate medical director part of that governance system. And that's again why the Belfast Trust moved towards that process of chair of division, which is very heavily dependant on governance, right? How I or 14:59

any of the other associate medical directors would have hoped to have done that in the time allocation that we had, I think, would have been a huge challenge because that would have been numerous governance meetings at that level. And I'm not making excuses but the time did not allow itself, you know. But in an ideal world, yes, it should have come up through a governance system in the way it would today. Yeah, yeah.

CHAIRPERSON: I'm so sorry, Ms. Tang. I'm just wondering, I mean, this was a purportedly a one-off incident, as it were, although it had got to a very serious level because there was a criminal trial. But if there had been allegations of multiple incidents of abuse and an investigation into multiple incidences of abuse, would you have expected to hear of those through some channel?

A. Yes, and I would have been quite concerned about that.

CHAIRPERSON: And you had been associate medical director since 2010?

A. Yes.

CHAIRPERSON: So can I just ask, when did you hear about Ennis?

A. I cannot specifically put a date on it, right, but I think it was -- I think, as I have said there, it was in around 2015/2016. I cannot remember the specific date.

CHAIRPERSON: Okay, thank you. Sorry, Ms. Tang.

180 Q. MS. TANG: That's okay.

Just staying on that topic for one last thing I wanted to ask you. Once you were made aware of that media report and the serious matter that it concerned, did that change? Did you perceive any change in how Muckamore was viewed by your consultant colleagues, or indeed your directorate colleagues at that point?

A. Not that I would have been immediately aware of. Now, 2015/2016, I was off on sick leave for about six/seven months, right - just thinking about the timing of all of this - so I don't know what would have happened during that time. But in terms of... I'm trying to think about what it was like whenever I came back from all of that. Certainly, based on all of that, I got -- I certainly got a strong sense that there was a greater awareness in relation to, you know, behaviours and restrictions and restraints and poor behaviour. I definitely was left with that sense after that.

181 Q. When you say poor behaviour, do you mean on the part of some staff or what do you mean?

A. Just I think in terms of that particular incident because, as I recall, it was in relation to allegations of a patient being dragged. I think, you know -- I think certainly there was discussion certainly across the directorate at that time in relation to restrictive practice, because obviously it was pertinent to everyone. Particularly when we were working with a frail, elderly population, we were working with people who were in Muckamore, and we had mental health patients, I think there was an increased awareness

that, you know, that had to be done; any kind of restrictive practice had to be carried out in a professional manner.

DR. MAXWELL: Is that informal discussion or was there a formal programme instituted by the directorate to look at that, or was it just people had seen it in the press and were having informal coffee time discussions about it? 15:04

A. My sense was that there was a bit more focus on it in the directorate meetings. Also, I mean, MAPA training is constantly in revision anyway, but my sense was that the MAPA training certainly was taking all of that into consideration as well in terms of emphasising to people the importance of proper handling, right. I don't remember at being at any specific meetings around restrictive practice in relation to that, yeah. 15:04

CHAIRPERSON: I have just realised that there may have been some misunderstanding when I posed my question about Ennis, when you first heard about Ennis, because you then said, "as I say in my statement, around '15/'16." 15:05

Had you heard about the Ennis investigation, which is much wider than this single incident?

A. I think I heard about it around that time, yeah.

CHAIRPERSON: Again may I ask through what channel did you rather it? How did you hear about it? 15:05

A. I don't know which came first, right. I had -- I don't know whether I noticed it in the paper first and then had a conversation with the lead for nursing, lead for

governance and the clinical director, or whether -- I don't think there had been any discussion about it before that. But I know that I certainly had a conversation with them about this nurse at that particular time, just to understand what that process was. There was mention at that time that there had been an investigation done.

CHAIRPERSON: But that related to an individual nurse?

A. As far as I understood it, yes.

CHAIRPERSON: You didn't know about any wider investigation? 15:06

A. No. I thought it was one nurse.

CHAIRPERSON: Okay, thank you.

A. Yeah. Yeah, yeah.

182 Q. MS. TANG: Can we go down to paragraph 28, please? You refer in this paragraph to having viewed CCTV footage and you alerted concerns to a number of colleagues, and you made Dr. H50 aware of your concerns. Can I ask what H50's reaction was? You should have the ciphers in front of you there. How did H50 react to the concerns when you made them aware? 15:06 15:07

A. Oh, he was really concerned.

183 Q. Did he seem to have any awareness of them before that?

A. No.

184 Q. Was there any discussion that you recall about how that would affect Muckamore, the pressures that the place was under to try and get sufficient numbers of staff et cetera? What kind of concerns did H50 raise? 15:07

A. So, at that time there was... I mean, this was done in

a very confidential way and that we were asked to come up and have a look at this. Again, there was discussion then about adult safeguarding and, you know, potentially involving the PSNI. So, you know, once you get into the realms of all of that, I suppose because those two processes very often run in parallel, there wouldn't have been much general discussion about this.

But the conversation that certainly we would have had would have been in relation to concerns about what had happened there and about what else needed to be done. There was some thought certainly at that time that there would be more CCTV would be reviewed. But again, I wasn't party to who was going to be involved in that, who was going to be asked to do all of that. 15:08

185 Q. Do you recall any concerns about how far this went, how wide scale this problem was?

A. Well, the sense I had at that point in time was that this obviously had been picked up inadvertently because I think there had been a query made - and again I'm working completely off my memory - but I think there had been a query raised in relation to the management of a patient on the ward, and I can't remember if it was the patient was raising the concern or the staff member was raising the concern. On the back of all of that, as I understand it, the CCTV had been trialed and had been switched on and I think was to have been switched off but wasn't, and then this was discovered inadvertently. I think that then was the beginning of

this, because they had gone back to see if any CCTV existed in relation to that, not expecting, I think, to find CCTV, and then realised it was there, saw that that problem was there and I think then that, as I understand it, had taken them then to start to look at other CCTV. 15:09

But the only part of the CCTV I would have had an awareness of was this particular bit to have a look at.

186 Q. The bit that you saw. When you were having your conversation with H50, or indeed the other consultants on-site, did you make any suggestions to those doctors about keeping a closer eye on things or being more alert? 15:09

A. I didn't. Because again this was being dealt with through the PSNI and adult safeguarding, as I understood it, I didn't have a wider conversation with the doctors there because, I mean, this was becoming -- potentially it was becoming a police matter. So I certainly... I know certainly at that time in the course of the discussion, it was mentioned that there wasn't -- you know, with H50, that there wasn't any sense that anybody had picked up anything before that in terms of having seen anything. 15:10 15:10

187 Q. Do you remember any steps that you took to reassure yourself that this wasn't a habitual issue, that these were exceptional concerns? 15:10

A. My memory is that I was divisional medical director for mental health at that point in time, okay, and I think,

again, in terms of involving the director for adult social and primary care and involving particularly the director of nursing, because this obviously was down nursing lanes, was to make them aware that I was concerned about all of this.

But I wouldn't have been in a forum at that point in time, you know, where I would have been actively expecting assurance in relation to all of this. As I understood it at that point in time, I was asked to look at this because I was familiar with the department and they wanted an independent opinion, and I passed on my concerns then to the directors for those areas. But other than to, I think, check - and again it was done on an informal basis largely at meetings - to ask the director if the investigations of proceeding in the way that they did and if there were any other concerns, I didn't actively set up any meetings to assure myself in any other way.

15:11

15:11

15:12

DR. MAXWELL: I presume you've got a cipher list there. Can you tell us who was the chair of the intellectual disabilities or learning disability division at that time?

15:12

A. H50.

DR. MAXWELL: So when you spoke to H50, you were talking to a peer, another chair of the division?

15:12

A. Yes, yes. Yeah, yeah.

188 Q. MS. TANG: I want to just pick up on one point that came up in our conversation earlier that related to

funding. You had mentioned that when you met with some of the medical staff at Muckamore, they would have raised concerns about the shortage of funding and the difficulty of getting access to certain specialist community placements. Can you tell me a little bit more than that? How common was that?

A. That was day and daily. Any time there was a discussion, there was a conversation about the lack of funding and that is what it centred on. Again, there was -- I know that, again, this would have been discussed at the directorate meetings repeatedly that, you know, the director and the assistant director and others had, you know, been back regularly to speak to the Eastern Board, as it was at that point in time, for funding to try and allow these patients to leave hospital. Again, there was always limitations to that in terms of what they could expect.

I mean, I know it was a constant source of frustration that, you know, particularly the operational managerial staff in there were trying to get these patients placed in the community and there was a shortage of places and then, when places did become available, they were, you know, understandably extremely expensive, these patients have very complex needs. That was a huge source of frustration.

189 Q. We've had some evidence from previous witnesses that have suggested that funding typically wasn't an issue, it wasn't the rate limiting factor for someone being

discharged. Is it your evidence that actually there were times when it was a direct barrier to someone getting out of hospital?

A. My sense was that it was a frustration in all of that, yes, yes, that there wasn't the funding there always that was needed. 15:14

190 Q. Would this have been particularly so with very complex needs or might it have happened with more straightforward patients as well, that there could have been funding pressures? 15:14

A. Mostly with people with very complex needs. You know, some people who maybe needed 3-to-1 care or 2-to-1 care on a fairly constant basis. Again, finding the specialist facilities that could offer that and making sure then that the placements didn't break down because of, you know, the infrastructure, I know was a constant concern to people. 15:15

DR. MAXWELL: Is it your impression that if the funding had been available, there were enough providers in the community who were willing to provide this service? 15:15

A. I think it was a chicken and egg situation. I think because the funding ended up being -- my sense was it ended up being quite reactive a lot of the time, that actually then putting forward planning into that was quite difficult. So, you know, where there was specialist provision, it came up with very small numbers and very slowly rather than actually being in place waiting for people to be received into it. 15:15

Again, I think that goes back to historically how poorly mental health and learning disability have been funded in Northern Ireland.

DR. MAXWELL: So would it be fair to say there needed to be a strategy where you created the capacity before you started looking to place patients? 15:16

A. Yeah, yeah. Absolutely, yeah.

MS. TANG: Dr. O'Kane, those are all of my questions but I'm going to hand over to the Panel in case there are any issues that they wish to pick up with you. 15:16

A. Okay. Thank you.

CHAIRPERSON: No, I think we have asked our questions as we've gone along. So can I thank you very much for giving up your time, it's been instructive and helpful. Thank you very much indeed. 15:16

A. Thank you.

CHAIRPERSON: I don't think there's any further reading to do, is there?

MS. TANG: No, not today.

CHAIRPERSON: Okay, so ten o'clock tomorrow. Thank you very much. 15:16

THE INQUIRY WAS THEN ADJOURNED UNTIL THURSDAY, 6TH JUNE 2024 AT 10:00