MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 12TH SEPTEMBER 2024 - DAY 103

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

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THE INQUIRY RESUMED ON THURSDAY, 12TH SEPTEMBER 2024 AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you. Just before we start with the witness, can I just mention next Tuesday, when we were going to be sitting in the morning, and in fact that witness was probably going to be Zooming from Australia, but in fact, she's going to be with us. This is -- sorry this isn't ciphered, is it? Sorry, I don't want to mention her name if it's ciphered. But it's Tuesday morning's witness. She will be with us at 1:30, so we won't sit in the morning, but we will sit at 1:30 that day. I don't think there is a cipher, is there? No, thank you very much. Catherine McNicholl. Okay. All right. Are we ready for the witness? 10:06 10:06 10:06

MS. BRIGGS: Yes, Chair. This morning's witness is H294, Service Manager at Muckamore between December '18 and August '19. The statement reference is 313. And there is a Restriction Order, RO84, the witness is to be referred to by her cipher. 10:07

CHAIRPERSON: Sorry. Right. Okay. So it's H294?

MS. BRIGGS: It's H294, Chair.

H294, HAVING BEEN SWORN, WAS EXAMINED BY MS. BRIGGS AS FOLLOWS: 10:07

CHAIRPERSON: We're going to refer to you as H294, as you've probably been told. So, H294, can I just thank

you for your statement. Welcome to the Inquiry. And just to say this, if you do reveal your name by accident, or anybody else's name that should be ciphered, please don't worry about it.

A. Okay. 10:08

CHAIRPERSON: We have a delay on the public feed that goes next door and to others, and we'll just stop the feed, it will take us about 30 seconds to sort it out, and the name doesn't go onto the transcript. All right? 10:08

A. Okay.

CHAIRPERSON: If you want a break at any stage, let me know, but we'll probably stop after about an hour and a quarter or something like that and have a break anyway.

A. Okay. 10:08

CHAIRPERSON: All right? Okay. Ms. Briggs.

1 Q. MS. BRIGGS: Thank you, Chair. H294, good morning.

A. Good morning.

2 Q. As you already know, I'm going to be asking you a series of questions in relation to the statement you've 10:08 submitted to the Inquiry, which is at reference 313, it runs to 17 pages, you have a copy in front of you, and it will also come up on your screen. Do you wish to adopt the contents of that statement as the basis of your evidence to the Inquiry? 10:08

A. Yes.

3 Q. So as background you tell us in your statement that you worked at Muckamore between December '18 and August '19 as a full-time Service Manager?

A. Yes.
4 Q. Is that right?
A. That's correct.
5 Q. And you worked as a Band 8B?
A. Yes. 10:09
6 Q. And, very briefly, your background is in nursing, isn't that right?
A. That's right, yes.
7 Q. You qualified as a nurse in 1993?
A. Mhm-mhm. 10:09
8 Q. And you worked in nursing homes, and after a time you became the manager of a nursing home, isn't that right?
A. Yes.
9 Q. And then after that you worked for the Belfast Trust for a number of years in different roles? 10:09
A. Yes.
10 Q. Care manager roles. And eventually your roles for the Trust were all roles which really involved changing or improving services?
A. Improving services, yeah. 10:09
11 Q. Is that fair to say?
A. Yeah, yeah.
12 Q. And in 2016 to '18, before you came to Muckamore, your job title was a Service Improvement Lead and Head of Governance for Commissioned Services? 10:09
A. Yes.
13 Q. Okay. I'm going to pick up at paragraph 7 at the bottom of page 2 of your statement. You're telling us at that paragraph that when you came to Muckamore it

was at the time after abuse had been revealed in the media?

A. Yes, yes, yes.

14 Q. And staff had been suspended.

A. Yes, yes. 10:10

15 Q. What was your initial impression of Muckamore when you got there?

A. Well, I suppose it was a ward situation, so I wasn't, you know, I wasn't used to a ward situation, so that was a wee bit, ehm, how would you say, a wee bit 10:10 different for me, because I had been working in the community and in nursing homes for quite a long time, so it was the ward and the fact that you had consultants at hand straightaway, you're not ringing a GP and things like that. So that environment was a wee 10:10 bit different. What I thought of Muckamore? Well, I mean, I found it actually quite welcoming. The staff were very, very nice. There wasn't - I didn't have any issues. You know, the staff were quite, ehm, I suppose apprehensive whenever I first came in, and they were - 10:11 I suppose they'd been through an awful lot with regards to the publicity and media, and I suppose feeling how everybody else felt about them, and that they worked in this hospital. But apart from that, I thought it - I mean I felt it was very, very welcoming. 10:11

16 Q. And what about the quality of care being given to patients?

A. I didn't see any major issues with the quality of care. It probably, in my, I suppose my view of it is that

it's like every service, you know, things need to be tightened up a little bit, you know the use of agency, you known, HR issues, things like that, it was no different than that. The quality of care I didn't have an issue with, with regards to the staffing levels on wards and things like that there. So it was sort of, I suppose like every other facility, I didn't see any major issues, you know, with regard to care.

17 Q. You said earlier that you felt the staff were apprehensive when you came in? 10:12

A. Yes.

18 Q. What do you mean by that?

A. I think because of all the publicity they were nervous. CCTV was in place and things had changed quite dramatically for them, and it was a big, I suppose a public, ehm, I suppose the public was looking at them and maybe judging them and things like that there. So they were a little bit I suppose lacking in confidence, lacking in, you know, assurance and things like that there, and it was - I felt that my role was to support them, let's, you know, "That's happened, let's move on, this is where we are now, so let's get on with it", and work through that and provide whatever supports we could during that time. 10:12

19 Q. And what did you think about the physical environments on the wards? 10:13

A. Well there was a few wards that, you know, weren't using, or should I say wasn't being used effectively, and this basically was, there was, you know, there was

two, two of the wards that were half full with patients and things like that there, so there was a sort of a waste, if I felt that kind of wording, that there was sort of a waste of area, and it was - there wasn't sufficient service users, or clients, patients or whatever, in both facilities, so we moved that into one to make it more like I suppose a warmer environment, plus you would have more effective use of your staffing and things like that. But as for the facility itself, I suppose there was a lot that wasn't used. I can only remember the Cranfield and Ardmore and that there, but the day centre didn't, wasn't used as, you know, an awful lot at that time, but as for the physical environment, I really didn't take much notice, if you know what I mean, you know that sort of... 10:13 10:14 10:14

20 Q. You mentioned there about two wards coming together.
A. Yes.
21 Q. Is that Donegore and Killead Ward?
A. Killead. Yes, Killead and Donegore, yes. And they were renamed Ardmore at that time. 10:14
22 Q. Yes.
A. Yes.
23 Q. I'll ask you about that later on because it is something that you deal with in your statement.
A. Okay. 10:14
24 Q. At the end of paragraph 7 there, you say at the very last sentence that you had no family or friends working in Muckamore at the time?
A. Yes.

25 Q. Was that something that was a bit of an issue in the hospital when you came to work as a Service Manager?
A. And what do you mean?
26 Q. Was it something that was raised with you that might have been a problem with the hospital, either at that time or in the past, family and friends working together in the hospital? 10:15
A. No, no.
27 Q. Were you aware of any family members or friends working together on wards? Sorry, I'll remove "friends". Were you aware of any family members working together on wards? 10:15
A. Ehm, yes, in relation to, ehm, I think it was Cranfield and Six Mile, I think there must have been a father and a couple of sons and that there, that had been there, but they weren't there whenever I came. 10:15
28 Q. How did you become aware of that?
A. Staff chatting.
29 Q. What would they be chatting about?
A. Basically that, what do you call it, there was three family members, and I think at that point they felt they were suspended, some of them were suspended and some of them had been... 10:15
30 Q. So it wasn't an issue that was raised with you in terms of something that the hospital needed to look at in terms of your role, family members working together, and the policies and guidance around that? 10:16
A. No. Absolutely not, no. No.
31 Q. Paragraph 8 then at the top of page 3?

A. Mhm-mhm.

32 Q. You're describing there how you started your role in December 2018. You say that you had no previous learning disability experience or training?

A. Mhm-mhm. 10:16

33 Q. You say that you did have experience with and had undertaken courses in physical health and disability, which included experience with dementia patients. Had you any prior experience of or knowledge about challenging behaviour? 10:16

A. Yes.

34 Q. What was your experience and your knowledge about that?

A. Well in relation to - within physical health and disability we have a lot of Korsakoff clients, and a lot of challenging behaviour in relation to addictions 10:17 and brain injury and things like that, that all sat under physical health disability. So I was fully - yes, I was aware of challenging behaviours.

35 Q. So you felt comfortable with working with people with challenging behaviours on your arrival at Muckamore? 10:17

A. Yes.

36 Q. And had you had any formal training in that regard or was it more experienced gained?

A. Just experience. Just experience.

37 Q. And in terms of no previous learning disability 10:17 experience or training specifically, do you feel that that hampered you in any way when you came into Muckamore?

A. No, I don't think so. I don't think so. Well, other

than I wasn't equipped to deal with MAPA training, I hadn't done the MAPA training at that time and wouldn't have been in a position to, you know, protect other staff or other residents from, what do you call it, from any challenging behaviours and things like that there. But, no. It wouldn't have been any different than any other ward that there was challenging behaviour on, that type of thing, I didn't think, no, they're still patients. 10:18

38 Q. You go on to describe, and this is at paragraph 10 on page 3, I'm going to summarise that paragraph. You say there that the nature of the role, as you were led to believe, was a learning disability service model transformation project? 10:18

A. Yes. 10:18

39 Q. You say you were given the direction to get Muckamore in line with the document "Delivering Together", and you say that your understanding was that the role was nothing do with the historical issues which had been uncovered, it was more working on the wards and getting things moving along. 10:18

A. Yes.

40 Q. Can you tell the Inquiry a little bit more about what you understood your role to be and, in particular, what Muckamore needed to change to bring the hospital in line with Delivering Together? 10:19

A. Okay. My, in my understanding of the role that I was going into within Muckamore was, I was going in as, I suppose a fresh set of eyes basically, to manage the

wards, manage the role, make changes, improve, start - how would you say it - moving people out into the community who were capable of living out in the community, starting that process. That's what Delivering Together is, is involving the community, being able to live out in the community in supported living units and things like that. So that was what I was - and to actually manage the buildings, or not the buildings, the wards and everything else, and make sure that they were running effectively, that the care that was given was good, if there was any incidents, access - just an overall manager, that's basically what I would have felt my role was, alongside of improving, you know, their ability to have community, I suppose, homes within the community, to live out in the community and not in institutional care. 10:19 10:19 10:20

41 Q. And when we think about the nature of change?

A. Yes.

42 Q. Which was your - you perceived your role as a change role? 10:20

A. Yes.

43 Q. What needed to change at Muckamore to bring Muckamore into line with Delivering Together?

A. Ehm, the only thing that I felt, there was patients within Muckamore could live well out in the community environment, they didn't need to be in an institutional, you know, environment. I felt there was some that were, they weren't challenging, they had like learning disability, they would have been, you know, 10:20

quite capable of living in nursing homes, care homes, you know residential homes, supported living homes, there was some clients. Now there was some that weren't, but there was definitely some that could. And that's what I felt that needed change, rather than sitting in the ward, you know, a ward environment. 10:21

44 Q. Were those particular patients not already on a track to being resettled at that point?

A. They probably were, but there was no manager. The Service Manager, there was no Service Manager in post at that time. 10:21

45 Q. And did your role live up to what you thought it was going to be, a transformation role?

A. Not altogether, but it was, it was beginning to be.

46 Q. Why do you say not altogether? 10:21

A. Because I left before it finished.

47 Q. But during the time that you were there, do you feel that you were in a change, a transformation role?

A. Yes, yes, yes.

48 Q. And would you say, looking back now, that you felt Delivering Together was successfully embraced by the hospital while you were there? 10:21

A. Most of the them, yeah, yeah. It was starting to, with regards to, you know the ward staff, I felt that they wanted change. I felt they wanted to move things along. The PIPA model we brought in and everything else, they really thought that was a really good idea, and they were - there was a lot in agreement with it. There was a few, which there always is, that don't 10:22

particularly like change. So that would have been...
49 Q. That's something you describe in your statement and we will come on to those individuals in a moment. You mentioned there the PIPA model?
A. Yeah. 10:22
50 Q. And that's an example you give in your statement of change?
A. Mhm-mhm.
51 Q. And that's at paragraph 12 at the bottom of page 3. You say there that you could see things improving, for 10:22 example, with the introduction of the PIPA model, and that's the "Purposeful In-Patient Admission Model".
A. Yeah.
52 Q. Introduced into Cranfield 1 Ward. And you do give detail about it. Can you tell the Inquiry what exactly 10:23 the PIPA process involved, what it looked like?
A. Oh, ehm, well all I can remember it was like a huddle at 9:00 o'clock in the morning and a huddle at 2:00 o'clock, so that new staff coming on, night staff/day staff coming on, that there was like a changeover, it's 10:23 the changeover that isn't long and laborious, it is basically very short and sweet and, you know, to the point, you know: Is there any changes overnight? Is there anything that needs to be done today? Priorities for the day. If there was anything at 2:00 o'clock, if 10:23 some of the staff were coming on at 2:00, they would get a brief outline if there was any concerns, any incidents, anything that had to be addressed, or any new -- something new. It was really to do with good

communication between staff and, what do you call it, the Ward Sisters, and making sure everybody was up-to-date with information at all times.

CHAIRPERSON: So as an acronym it's not actually very accurate, is it? 10:24

A. Pardon?

CHAIRPERSON: Well, it's called Purposeful In-Patient Admission.

A. Yes.

CHAIRPERSON: But it's actually it's a purposeful in-patient review? 10:24

A. Yes.

CHAIRPERSON: It's nothing to do with their admission?

A. No.

CHAIRPERSON: No. 10:24

A. No. Unless there was a new admission.

CHAIRPERSON: Sure.

A. But there was very few new admissions.

CHAIRPERSON: But it affected all the patients who were there, and it was effectively a good handover model. 10:24

A. Yes, yes.

53 Q. MS. BRIGGS: You describe it as a "safety pause" in your statement.

A. Well, safety pause, huddle. I call them huddles now, but, yes, they were a safety pause, and if there was 10:24 any concerns - and that involves in a huddle nowadays as well.

54 Q. And you say later on in your statement, it's at paragraph 22, you say that staff were very appreciative

of it coming in?

A. Mhm-mhm.

55 Q. Is that because it made things move along faster, is that why?

A. It made things move along faster. It involved your care assistants as well as your nurses and things, so it involved all the staff, so they all knew what was happening on that day, if there was anything. I think it just improved communication and they felt involved as part of the ward. 10:25

PROFESSOR MURPHY: How did it differ from a handover?

A. Well, when I -- the handovers were very long and nurse to nurse orientated. Well, the consultants weren't always there. But they were long, they went through all of the patients and there was a lot of, how would you say it, a lot of talk, and maybe it wasn't highlighted what was the purpose, you know. How would you say? What is the priority for today? Who is most at risk? Who is the most vulnerable? What are we doing? You know, had there been an incident overnight? Was anybody in seizures? Things like that there, that sort of thing. So that's where it, it boiled it down to very short and sharp. 10:25 10:26

PROFESSOR MURPHY: More focused?

A. More focused. Far more focused. 10:26

PROFESSOR MURPHY: Okay.

56 Q. MS. BRIGGS: If we can go on to paragraph 14 on page 4. Here and in the previous paragraph you're describing some of the day-to-day roles you had as a Service

Manager. At paragraph 14 there you're describing your weekly Muckamore meeting with H296 and the Director of Nursing, as a means of oversight of how things were going in the service.

A. Mhm-mhm. 10:26

57 Q. You say you looked at incidents, accidents, and audits, to ensure everything was done appropriately. You say you were also dealing with family complaints and setting up care forums. You were looking at the day-to-day running of wards, ensuring staff and 10:27 patients were safe, getting what they required, and that their needs would be met. The Inquiry has heard evidence that by this time the majority of ward staff in Muckamore were agency staff and not LD trained. What challenges did that present for the hospital? 10:27

A. Ehm, well, there weren't agency staff like agency staff now, where there was one agency coming in and another one going out. These were regular agency staff. They knew the patients. I didn't have an issue with agency staff, apart from the cost of it, but other than that 10:27 they were - they might have been agency staff, but they were longstanding staff that - they were like block booked type of thing. But it certainly isn't like it is today where it's a lot of in and out. They were blocked booked at that time. So they were well aware 10:28 of the clients and everything else. There was very little, that I can remember now, that were coming off that were, you know, walking in. But they would have to have an induction and things like that carried out.

DR. MAXWELL: But the Inquiry has heard that they were not on the LD part of the NMC Register. They were mental health nurses.

A. Right.

DR. MAXWELL: So are you saying it didn't matter that they didn't have a training in learning disability? 10:28

A. I wouldn't say that, but I really don't know.

DR. MAXWELL: I mean we've heard about the skills required - by the time you were there it was the most complex patients who were left in the hospital. Those who it was easy to organise resettlement had already had been resettled. So these were very complex people with challenging behaviours. 10:28

A. Mhm-mhm.

DR. MAXWELL: And yet a lot of the workforce had no training in managing people with a learning disability with complex behaviours? 10:29

A. Well, I don't -- in my time I don't remember ever anybody coming to me and saying that they weren't trained up, or they weren't - they didn't feel that the staff there was, that there was an issue or anything. 10:29

DR. MAXWELL: Sometimes people don't know what they don't know?

A. Okay. Well, I can't answer that. Sorry.

CHAIRPERSON: And I suppose the fact is, you weren't LD trained yourself. 10:29

A. No.

CHAIRPERSON: So you might not have recognised the distinction?

A. Yeah, maybe.

58 Q. MS. BRIGGS: In terms of looking then at incidents, accidents, and audits, that's something you say you looked at.

A. Mhm-mhm. 10:30

59 Q. Was that a paper type review of the documentation that would have been submitted by staff on the ward? What did your looking at involve exactly?

A. I actually can't remember how they formatted it, but it would have been, the Sisters of the ward would have 10:30 been giving me, I suppose facts and figures about incidents and any ones that were concerned, but I actually cannot remember what format they came in, whether it was computerised or whether it was paper.

60 Q. So in a sense you're looking at what you're told by the 10:30 Ward Sister and what is perhaps on paper, would that be your evidence?

A. Well, the Commission -- at that stage I think the Commission Service it would have been, the incident form would have been put through to what you call 10:30 Commission Services in Knockbracken. So they would have -- they're bound to have had a report, but I honestly cannot remember, but I'm assuming they would have a report of what incidents, an electronic, and that would have been the Sisters on the ward, or the 10:31 staff on the ward, would have put an incident form in in a computerised system, and then we would have been able to collate the number of incidents within. No, it wasn't -- it wouldn't have been a paper copy, I

wouldn't have been paper counting, it would have been put through a proper...

61 Q. And was that simply to formulate a number of incidents in a ward? Was that what your role was in that regard? Why were you looking at -- 10:31

A. It breaks down how many falls there had been, how many challenging behaviours, how many - that type of information. And as I said in the statement, if there was any that was really that we had great concerns about, or wasn't recorded properly or whatever else, we 10:31 would have been addressing that.

62 Q. Did you have those type of concerns?

A. Did I have them concerns?

63 Q. Such as information not being recorded properly?

A. I honestly don't remember, but I would, would have had 10:32 -- I'm sure there was incidents at that, but I would have been asking them to rewrite it or re-send it or whatever else. Or I would have been inquiring more of what had happened.

64 Q. But you can't recall any specific examples of that 10:32 happening?

A. No, no.

65 Q. If we can go down to paragraph 17? This is at page 5. You say there that when you first arrived you felt that the staff could not believe what was happening with the 10:32 press and media coverage?

A. Mhm-mhm.

66 Q. Was that a sense of shock amongst the staff?

A. What do you call it, yes, I suppose it was. It was a

bit of -- I suppose they were, as I said earlier, they felt, you know, their confidence has been lost and they felt that, what do you call it, they couldn't believe that this had actually happened.

67 Q. Was there any work being done with staff members at that time to help them understand what had happened, how it was being investigated, and also what had been seen in the course of the investigation? 10:33

A. Yes, they had OT, they had Human Resources, I think the senior manager within Human Resources. There was a counselling service for staff. There definitely was. 10:33

68 Q. You go on in that paragraph to describe two staff members who you felt some negative atmosphere from, that's H214 and H491.

A. Mhm-mhm. 10:33

69 Q. You say that they were -- this is about a third of the way down that paragraph:

"I felt that they were somewhat stuck in their ways, they were not happy to change, and I believe they found my way of working more modern and more accountable." 10:34

What do you mean when you say they were stuck in their ways?

A. I mean they had been there for an awful long time and they didn't like change, they didn't want to change. Ehm, I suppose I felt that they were the night sisters, I didn't feel that they were I suppose doing the job that I felt they should have been doing with regards to 10:34

overseeing the wards, whether they were, you know - I mean I can't remember what I had asked them to do, but I know it was more than they had been doing, and with regards to accountability during the night-time and working opposite each other, as a night sister should be, and being available at all times for all of the wards.

CHAIRPERSON: What do you mean by working opposite each other?

A. What I'm saying is, you know, if somebody is working Monday, Tuesday, Wednesday night, that the other is working Thursday, Friday, Saturday, you know, that there's always a night sister on the wards. And what do you call it, that they -- I would have imagined that I had asked them to link in together at some, one night, or a few hours, you know, to communicate to each other if there was any issues and things like that there.

CHAIRPERSON: Yes.

A. But I felt they stayed in one, one unit all night, and didn't go round, where I was asking them to go round all of the units.

CHAIRPERSON: And can you remember any specific example of something that you saw which you thought they ought to be doing that they didn't seem to be doing?

A. I think it was arranging or helping the nurses at night to get staff for the next morning, if anybody had rung in sick and things like that, and actually physically having a physical presence on every ward.

CHAIRPERSON: So walking the wards?
A. Just walking the wards. Just going and checking if everybody was okay, if there were any issues and things like that there. I think they spent a lot of the night previously in one area of the hospital and... 10:36
CHAIRPERSON: Does that mean in an office? That was a nod and a smile for the transcript. So I think you're agreeing. Is that fair?
A. Sorry. Yes, yes.
CHAIRPERSON: Yes. Okay. 10:36
PROFESSOR MURPHY: Given when you came to the hospital, had you wondered whether some of these staff had been perhaps rather badly bruised by what had been going on and did you talk to them about that? And whether it was affecting their commitment to providing a good 10:36 service?
A. Well, I personally don't remember. I know I provided some support, or, you know, support for whatever staff, and I know going by my experience and the previous work that I've done, I have always been there for staff, I 10:37 have always had the door - the door was always open. If there was any issues, if there was any concerns, if people needed time out, there was no problem, absolutely none. But, I honestly don't know any specific thing, any specific, but I would like to hope 10:37 - because that's the way I would tend to work, and I suspect I probably, I would have offered them support, but I honestly can't remember. I know some of them had said to me whilst they were on the wards that they

were, it was - they were disappointed in all of it and they were, you know, I suppose - how would you say it - maybe it's an element of grieving or whatever else, for the simple fact that this is not the Muckamore that they thought it was. I think that's what they were, you know. And disappointed maybe in their co-workers, disappointed that this had happened, disappointed that CCTV is monitoring them day-to-day, and things like that. And maybe the lack of trust on them, you know, and I suppose their co-workers disappointing them. 10:38

PROFESSOR MURPHY: Thank you.

70 Q. MS. BRIGGS: You say that H214 and H491 were not happy to change.

A. No.

71 Q. Did they express an objection to you? 10:38

A. Yes.

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

A. I can't - I don't know the details, but I know they weren't happy. I know they weren't happy.

73 Q. Did they say that to you that they weren't happy? 10:38

A. Oh, yes.

74 Q. And can you remember what they weren't happy about?

A. Having to walk the wards. Not being sitting in an office all night.

CHAIRPERSON: Sorry, can you keep your voice up? 10:38

A. Sorry. Just having to walk the wards, you know, go to each ward, you know, visit each ward. They weren't happy at not sitting in one area all night.

75 Q. MS. BRIGGS: So tell me if I'm getting this wrong, but

did you have a discussion with them to say "you ought to be walking the wards" --

A. Yes.

76 Q. -- and they responded to you and said that they weren't happy about that? 10:39

A. My memory, and I don't remember it, but I would imagine I have done it. But I know they had objections. I can remember that.

77 Q. And you say that you believe that they found your way of working more modern? 10:39

A. Yes.

78 Q. Is that simply in reference to the need to walk the wards, or is there something else that you're feeling there?

A. It's accountability. I mean I felt that they thought, 10:39 you know, they were accountable. Ehm, yes, probably walking the wards and putting face to face on what was happening.

79 Q. And did their approach, in terms of sitting in the office, did it have any impact on patient safety? 10:40

A. I couldn't tell you. I wasn't there when they were sitting in the office. But I'm assuming that, you know, it's better to see - it's supportive for your Sisters or your nurses on the ward that there's somebody walking, you know, coming in and seeing if 10:40 everything is safe and if there's any issues, I would imagine. How it would provide safety, I am not sure.

80 Q. You describe in the next few paragraphs the wards, and you help the Inquiry by telling the Inquiry what the

wards were like. You say that you witnessed a lot of good care?

A. Yes.

81 Q. And you say that you didn't have any real issues or problems with staff on the wards, and you also give the Inquiry an example of an assault that you saw, a patient assaulting a staff member? 10:40

A. Mhm-mhm.

82 Q. On Christmas Day on one of the Cranfield wards, and that's paragraphs 19 and 20 on page 6? 10:41

A. Mhm-mhm.

83 Q. Coming from a nursing home background and community background, and this being your first time in a learning disability setting...

A. Yeah. 10:41

84 Q. What did you think of incidents like that happening?

A. What did I think? In what regard?

85 Q. Did it shock you? Did it surprise you?

A. Yes. Ehm, the young fella in question was extremely, ehm, fine of body, if you know what I mean? He's quite a small young fella. And the quickness of him being able to grab that nurse's hair bobble, it stands out. He was so quick. And take her to the ground. And, sorry, what did you ask me again? 10:41

86 Q. What was your reaction to it? Were you shocked or surprised or something else? 10:42

A. I was, I was. I was shocked. I was shocked. And I did say to the girls, to the girl "Are you all right?", you know "Are you all right? Why are you doing this?",

and "I love the patients", and things like that, and I found that, you know, God, you're a whole good un.

87 Q. What about the other staff that were there and perhaps more used to things like that this happening.

A. Yes. Yes. 10:42

88 Q. Were they less shocked than you? Were they shocked?

A. Oh, no, they weren't shocked, they were very professional.

89 Q. Okay.

A. It was I -- I was at the back watching this happen. 10:42 So, no, they were calm the whole way through it and everything else.

90 Q. Did you get a sense then that they were used to things like this happening and they knew how to deal with it?

A. Yes. Oh, absolutely. 10:42

91 Q. Did you get a sense that there was a support system available to those staff, even though they might have been used to or were used to things like this happening, that they could reach out and get support if they wanted it? 10:43

A. Yes. Yes.

92 Q. What was that support?

A. Well, I mean, what do you call it, they were taken aside, and I mean from what I can gather that's normal process, that the girl, you know, needed, you know to 10:43 go, take a few minutes. If she felt that she couldn't work the rest of the day, that was fine, that wasn't, you know. If she was hurt, if anybody was hurt or whatever else, I mean that -- well that's what I had

put in place at that time. But from what I can gather, that was the normal practice, that they got taken away, you know, get a cup of tea, you know, get yourself together, and if you feel you can work, that's fine.

93 Q. That deals with perhaps the short-term immediate support that might be needed in that situation? 10:43

A. Yes, yes, yes.

94 Q. What about in the medium term or the long term, the days that follow if something like that happens and it sinks in for the staff member, did you get a sense that there was support available to the staff and that they were availing of that support? 10:44

A. I am not - I know the support is available, because Occupational Health has it available for all of the Belfast Trust. So I mean all, you know, all wards, all of that, no, Occupational Health were there, lift the phone, give them a ring, see if there is counselling, if they needed counselling, there would be no objection to that, because I have done it in other roles and things like that there. But, ehm, yes, I mean there would have been support - whilst I was there, there would have been support, and I mean if somebody needed to take time out, and some of them did - what do you call it - they would have been given that, you know, they've been taken off sick or taking, you know, a few days off and come back. I suppose it's like everything else, if they needed to change ward for a while and not work with that particular person, they would have been, you know, removed from that caring role of that person. 10:44 10:44 10:44

95 Q. At paragraph 21 of your statement, this is the bottom of page 6, you say there that you don't recall any incidents of poor care. If there was an issue, you say would you have spoken up about it and had it dealt with. The Inquiry has heard some considerable amount of evidence from patient family members that there was abuse, or poor care, or neglect, happening in 2018/2019. Did you not see or hear anything about that at all happening at the time? 10:45

A. No. 10:45

96 Q. Perhaps you may have heard in the media or otherwise, if you followed the Inquiry, some evidence being giving about poor care, or neglect, or abuse in the period that you were at Muckamore. Have you heard anything like that and have you reflected on it and thought "Well, how come I didn't know about it?" 10:46

A. No. Ehm, I didn't hear anything.

97 Q. Does it surprise you to hear now that that type of evidence has been given to the Inquiry?

A. Well, I suppose, yes. 10:46

98 Q. You go on in your statement to tell the Inquiry about your role in overseeing staff resourcing, admissions of patients, and you also talk about overseeing incidents involving patients. I'd like to pick up on the topic of patient incidents. If we can go to paragraph 27, on page 8. You're describing at paragraph 27 that if there was a patient involved in several incidents how that would be addressed? 10:46

A. Mhm-mhm.

99 Q. Okay. You say there that:

"We may have discussed putting in place preventative measures, including having more staff on at a certain time of the day, one-to-one supervision for a patient and/or asking the family to come in at a particular time of the day. Sometimes families would assist with feeding, which we would accommodate, or if we needed to feed patients separately we may have required additional staff to allow time to do this. We would assess the triggers for the particular incidents." 10:47 10:47

What about activity levels for patients? Was that considered a trigger for challenging behaviour?

A. Ehm, probably. Honestly I can't remember, and that's being honest. But I would say so now, yes. Boredom would be a trigger for... 10:48

DR. MAXWELL: And was that actually considered? When assessing each individual incident, would you have collected data about the meaningful activity that the patient had been involved on that day? 10:48

A. Activities? I can't remember, but I don't think day centre was up and running at that point. I honestly don't remember. But if it had have been, you know, that would have been definitely been an area I would have been trying to push for and carrying out activities, but I suppose -- 10:48

DR. MAXWELL: But it wasn't actively collected in understanding why the incident occurred?

A. When it happened? No. I honestly - I can't remember, and that's being honest.

DR. MAXWELL: Okay.

CHAIRPERSON: But you did have a role in resourcing?

A. Yes. 10:48

CHAIRPERSON: And work allocated. Is that not affected by the amount of activity that the patients need?

A. It probably would have been, yes, putting additional -- well, if it was now, putting additional resources to provide activities. 10:49

CHAIRPERSON: So you must have known about the activities and what was available to patients?

A. Yes, yes.

CHAIRPERSON: So how did you factor that in to your resourcing? 10:49

A. Well that's what the day centre, the day care, the day care was for, and I was - I can't remember, but I would imagine I was planning to open the day care again or else use resources from day care out into wards. That's what I would have planned. 10:49

CHAIRPERSON: But you can't remember if that happened?

A. No.

PROFESSOR MURPHY: You've said several times the day care was closed. Did you wonder why that was?

A. I probably did, but I, I don't know. By going in, 10:49 there was quite a lot to take on when I first went in, so I suppose for me it was, the priorities were getting the staff back, getting the wards back, you know, working and things like that, and then that would have

been a step, I suppose, if I had of stayed on.

PROFESSOR MURPHY: So for patients who were living there for a long time, which lots of them were.

A. Mhm-mhm.

PROFESSOR MURPHY: The loss of day activities surely would have been a major issue? 10:50

A. Mhm-mhm.

PROFESSOR MURPHY: But it didn't re-start while you were there?

A. [Witness shakes her head] 10:50

MS. BRIGGS: The witness shook her head for the transcript.

A. Sorry. No.

100 Q. MS. BRIGGS: If we can go to another issue, and that's CCTV, okay, and that's paragraph 30 at page 9? 10:50

A. Yeah.

101 Q. You're telling the Inquiry there that CCTV had already been introduced by the time you came to Muckamore, and you say that you personally didn't have any issue with it, but you do say that some staff didn't want it? 10:51

A. Mhm-mhm.

102 Q. You say that you didn't think it was fair that they were being televised all of the time, and they saw it as an invasion of privacy and felt they were not trusted. And you say you can't remember which staff or 10:51 which ward felt that way. Do you know whether any staff had raised concerns about CCTV before it was installed?

A. I'm not aware. I don't know.

103 Q. Mr. Ingram gave evidence to the Inquiry yesterday and his evidence was that he didn't receive any pushback from staff during his consultation process.

A. Okay.

104 Q. Prior to the CCTV being installed. So there's nothing that you heard or saw that would doubt that or cast doubt on that? 10:51

A. Say that again?

105 Q. You didn't hear any staff say to you "Well I" --

A. That they objected? 10:52

106 Q. -- "I expressed my concerns before the CCTV came in."

A. No, I didn't. No, I didn't.

107 Q. If we can go to paragraph 31, this is the bottom of page 9. You say there:

10:52

"I do not know the level of family involvement before I worked at Muckamore. However, one of the purposes of my role was to involve families more because it was a very delicate time and to have much better communication with them. For example, by involving the families in decision making." 10:52

A. Mhm-mhm.

108 Q. What structures or processes did you put in place to ensure the involvement of families more? 10:52

A. I know there was a meeting, a family focus meeting or something like that there, but how often and - I know I was at one of them, but I honestly couldn't tell you about the rest. My memory doesn't allow - well, I

don't remember how many I was at, but I know they were up and running.

109 Q. You say that you - one of your roles was to involve the families in decision making?

A. Yes. 10:53

110 Q. Can you recall anything about how that was done?

A. No.

111 Q. All right. Another topic that you describe in detail in your statement is resettlement. If we can go on to page 10, at paragraph 32. You say there that you 10:53 weren't heavily involved in the resettlement process. You say that in your statement.

A. The day-to-day.

112 Q. The day-to-day.

A. The day-to-day stuff. 10:53

113 Q. Yes. Because later on in that paragraph, about halfway down, you say that you were accountable to H296?

A. Yes.

114 Q.

"As to why resettlement was not happening, what the 10:53 problems were, what the options were, if there had been anything we could do to improve the situation to get patients out of the hospital to live their lives in the community."

10:54

What were the big issues facing you and other Service Managers in terms of resettlement?

A. I suppose having facilities out there. Having domiciliary care packages that would accommodate

challenging behaviour. Ehm, and having I suppose - basically that would have been it. I don't think - I mean some of the patients would have been very, very difficult to settle out in the community, that I can remember that particular one, but it's like having facilities that were suitable for them.

115 Q. Did a patient with a higher degree of learning disability, did that effectively always mean a higher level of complication for their resettlement?

A. Not necessarily. It's the challenging behaviour would be the most difficult thing for other community, you know, domiciliary agencies and that there to work with. But because they were, you know, had some physical, you know, and learning disability, that was - how do you grade it? It's just about being able to manage them and care for them. 10:54 10:55 10:55

116 Q. So the patients with the highest levels of challenging behaviour, or the most challenging levels of challenging behaviours --

A. Yes. 10:55

117 Q. Those were the ones that were the most complex in terms of resettlement?

A. Yes. Yes.

118 Q. Did you ever come to the view with any patients that they'd be better off in a hospital environment such as Muckamore, rather than out in the community? 10:55

A. At this minute, I don't know whether it would be Muckamore or whether it would be a facility that, you know - there is people that - well, to me, could not

live in their own homes. There's definitely that there. But there is, you know, there is an area that we need to look for in all, I suppose. Like we're talking about our challenging behaviour with our addictions and things, and there is facilities out there that we need to, that they cannot live out in the community, and they need close observation and they need to be looked after in a unit, whether that be Muckamore or not, I don't know. 10:56

119 Q. A hospital type environment or something else? 10:56

A. Well, I mean - well they probably - they need 24-hour care. They need, you know - you know, there's a lot of them are self-harming, things like that there. Seizure activity is very high. So it would be like a nursing environment, but maybe not necessarily - well, not a big institutional unit, it would be a nice comfortable, well looked after unit, you know, that's smaller, that will accommodate whatever, you know, how many there are. 10:57

120 Q. You say earlier in that paragraph that if placements broke down you sometimes became involved in the discussions or the planning about that? 10:57

A. Yes.

121 Q. What did you perceive as the main reasons for placements breaking down? 10:57

A. Placement is that - I suppose it took a wee while for the clients to go out, or the patients to go out into the community, get adjusted. Also families maybe didn't particularly like, they liked the security of

the hospital environment, but it would be - the main challenge would probably be the challenging behaviour. That would have been the crux, that people did not want to work with some of these clients.

122 Q. And was learning taken from that, when a placement broke down, that this is the reason why it's broken down? 10:58

A. Yes.

123 Q. And here's what we can do next time around or with other patients? 10:58

A. Yeah. I mean there was options for one-to-ones to go out into the community to work alongside of these patients over a 24-hour period if it made it, you know, more suitable or whatever else. It didn't always work, but that would have been one of the options. 10:58

124 Q. If we can go on to paragraph 33, it's the bottom of page 10. You're describing there meeting with a Family and Friends Group. You say about halfway down that paragraph that you were providing reassurance, you were providing assurance that investigations were advancing, that Muckamore were on top of things: 10:58

"...that we were dealing with any further incidents or that there were no further incidents. I provided assurance that incidents had been dealt with, recorded, and that adult safeguarding was high on our list of priorities. I gave assurances that nothing was being hidden and all appropriate action was being taken when an incident occurred relating to patients." 10:59

That's quite a comprehensive and voluminous set of assurances. Were you satisfied that the assurances you were giving were accurate and that you had enough information to give those assurances?

A. Well, as far as I was concerned that is what I was doing. I was giving them as far as - I was given, the information that I was given from senior management is that the Inquiry was going ahead, that - what do you call it - all incidents that I received in front of me I dealt with. Any complaints, I dealt with. I wasn't hiding anything, as far as that was concerned. And any appropriate action that needed taking, I would be taking it.

125 Q. And what about those who were also involved in the investigations, the ASG investigation, were you satisfied that everything was being done when you were reporting that back to --

A. Well as far as I was concerned, because that was being reported to me.

CHAIRPERSON: But did you make any enquiry? Did you ask for the sort of source material? Did you dig into it to look at a particular incident, for instance, and see how far it had got in the particular ASG process, or were you just being giving assurances and you passed those on?

A. Well, I mean there was social workers within that, within Muckamore Abbey, and they were professionals as far as I was concerned. I was the overseer of all

these incidents. Yes, if there was something very serious I would definitely be looking into, I would definitely be sitting having a meeting with the staff and saying "How can we deal with this?", or "What do we deal with this?", or whatever else. But I would be assured that I would be doing that. But as for the role, the social workers role within the hospital, that would have been their role with regard to adult safeguarding. Do you know what I mean? 11:01

CHAIRPERSON: I do understand that, yes, certainly. 11:01

A. Yes.

CHAIRPERSON: But it's just a question of whether you were over the detail, as it where, as opposed to simply passing on reassurance?

A. No, no, no. I would have been involved in the - what do you call it? I would have assumed, if I can remember what adult safeguarding issues were, thing, but I would never - we would always be meeting about them. There would be no letting them go and just saying that "No, that's okay". But you have to, you know, you can't be over - and I don't mean this to be rude, but you can't be over every single detail. 11:01

CHAIRPERSON: No. No, I understand.

A. Do you know what I mean? Because you're doing so much.

CHAIRPERSON: Thank you. 11:01

126 Q. MS. BRIGGS: I want to move on to something else which is ward mergers, and we talked about it briefly earlier.

A. Yes.

127 Q. This is at paragraph 40 of your statement. It's paragraph 12. You describe there in particular the merger of Killead and Donegore Wards.

A. Mhm-mhm.

128 Q. You describe that the wards had to be merged because there were a small number of patients on those wards and that the decision to amalgamate was communicated to you by the Director of Nursing? 11:02

A. Yes.

129 Q. And you say that you conducted a consultation with staff, patients, and families on both of the wards? 11:02

A. I would have, but I actually cannot remember an awful lot about it, but that would have been the process.

130 Q. You say, it's towards the end of the paragraph there, and I'm just going to read it out: 11:02

"I conducted a consultation with staff, the patients and their families on both wards."

Are you saying now that you can't recall whether you did that consultation? 11:02

A. Yeah, I'm not 100% sure.

131 Q. You're not 100% sure?

A. No.

132 Q. So that sentence you don't think -- 11:03

A. That would have been my normal, and that would have been -- but at this minute in time I can't remember.

133 Q. Okay.

DR. MAXWELL: Can I just ask? It's a bit unusual to be

told this decision by the Director of Nursing, because she's not responsible for the operational management of Muckamore, and usually a consultation would be undertaken before a decision was made, not afterwards?

A. Aye. Well, I mean that decision was -- 11:03

DR. MAXWELL: Yeah, the Director of Nursing.

A. Okay, Director of Nursing. The decision was the Director of Nursing to amalgamate both of the things, and myself and the other nurse - let me see if I can remember her name? Where is she? H394. Both of us 11:04 were involved in the amalgamation of that.

DR. MAXWELL: So you weren't aware of or involved in any of the discussions about whether they should be merged? You don't know how that decision was --

A. Made. 11:04

DR. MAXWELL: Arrived at.

A. No.

DR. MAXWELL: You were just told to implement it.

A. Yes.

CHAIRPERSON: So even if you did have conversations 11:04 with staff, patients, and families, which you don't remember, it wouldn't be right to call them a consultation, would it?

A. Pardon?

CHAIRPERSON: Well a consultation means that you're 11:04 considering doing something and asking people how best to do it or whether to do it. This sounds as if it had - the decision had been made.

A. Made.

CHAIRPERSON: And you were simply informing people --
A. Well, I honestly don't remember. But in my - if I can remember, and I wish I could remember it, but I can't - that would have been normally my process sitting talking to families. I'm nearly sure we did it. I'm nearly sure we did it. 11:05
CHAIRPERSON: But before the decision was made or after the decision?
A. Before the decision. Oh, we would never, we would never move anybody and just say "We're moving you". 11:05
CHAIRPERSON: But there are no notes of that?
A. There could be.
CHAIRPERSON: There could be.
A. But I don't work for Belfast Trust anymore, so I honestly... 11:05
CHAIRPERSON: No, I understand.
A. I've no access to any of that.
DR. MAXWELL: So the decision had been made and you were asked to operationalise it.
A. Yes. 11:05
DR. MAXWELL: Was there any sort of consideration about the change management, how that was going to be achieved? Was there any particular methodology used to do this?
A. I'm sorry, I cannot remember. 11:05
DR. MAXWELL: You can't remember.
A. Sorry.
PROFESSOR MURPHY: I think you said at the beginning of your evidence, something like you felt there were half

empty wards in Muckamore and it wasn't efficient.

A. Mhm-mhm.

PROFESSOR MURPHY: Do you think this decision to amalgamate the wards was really about finances?

A. It probably - there's an element, yes. But it also was about -- well, it was also about I suppose having a ward that was fully functioning and it was more a community, you know, having, you know, a half-empty ward, it's cold, if you understand? You know, if one ward is cold and the other, you know, with the lack of clients or patients in them. Whereas you would have one and you would have regular staff, there would be, you know, there'd be more staff there to cover each other, and things like that, that would have been part of the thing. It probably is resources as well, and definitely finance would have been a factor in it as well. 11:06 11:06 11:06

PROFESSOR MURPHY: But for people with autism, actually it's quite stressful to be with a lot of other people. Was that taken into account? You know, lots of the patients in Muckamore had autism challenging behaviour and they didn't necessarily want lots of other people around? 11:07

A. Okay. Well, I mean I am not sure whether that was taken into consideration. I'm sure it was taken into consideration, because the Ward Sisters would have objected severely to it, I am sure. 11:07

PROFESSOR MURPHY: And they weren't objecting?

A. Not that I'm aware of.

CHAIRPERSON: And could I just understand what your role was? The decision to close the ward, you say in your statement, was communicated to you.

A. Yes.

CHAIRPERSON: So what did you then need to do? What was your role? 11:07

A. My role was to see how we could amalgamate the two wards.

CHAIRPERSON: Right.

A. And as far as I would remember, or don't remember - I can't - but if it was me, it would be my role to consult with families, you know, when the move was going to take, how was it going to take, how was the staff, what staff would move, who wanted to move, who didn't want to move, you know, was there any other options? Things like that there. It wouldn't be just -- I'm not that kind of cold kind of person just to move somebody. 11:07 11:08

CHAIRPERSON: And can you remember taking any advice specifically from learning disabled professionals as to what the best way would be to make this change? 11:08

A. No. I don't remember.

CHAIRPERSON: Thank you.

134 Q. MS. BRIGGS: You do say that the Ward Sister who took over the amalgamated ward was not happy about the merger, can you recall that? 11:08

A. I remember her not being happy, but what the reasons for or not, I don't know. But there was also two Ward Sisters there.

135 Q. The Inquiry has heard evidence earlier this week from a Band 8A Service Manager who was a longstanding former nurse at the hospital, that the ward merger was reactive. She said there was an instruction given, little consultation took place with staff, patients, and families. What would you say about that?

A. I, I honestly don't remember.

136 Q. Were you involved in any other mergers during your time at Muckamore?

A. Not that I can remember. 11:09

137 Q. Can you remember if there was any learning taken from the Donegore and Killead Ward merger, anything learned that might have been used in the future, knowledge gained?

A. No, I can't remember. 11:09

138 Q. Okay.

MS. BRIGGS: I wonder if that's an appropriate time for a break, Chair?

CHAIRPERSON: How much more do you think you've got to go. 11:09

MS. BRIGGS: About half an hour.

CHAIRPERSON: Sure. Certainly. We normally take a break around now just to give the stenographer a rest and you a break.

A. Okay. 11:10

CHAIRPERSON: So we'll be about 15 minutes. You'll be looked after.

A. Okay.

CHAIRPERSON: Please don't speak to anybody about your

evidence.

A. Pardon?

CHAIRPERSON: Please don't speak to anyone about your evidence. All right?

A. Okay. No, no, that's fine. That's fine. 11:10

CHAIRPERSON: Thank you.

A. That's grand.

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS: 11:10

CHAIRPERSON: Thank you very much. Yes, Ms. Briggs.

139 Q. MS. BRIGGS: Thank you, Chair. H294, I want to go down to paragraph 41 at the bottom of page 12.

A. Yeah. 11:36

140 Q. Now, I appreciate this is difficult for you to talk about because you tell us later on the terms on which you left Muckamore; you went on sick leave due to stress, and I know that this is difficult, particularly the next couple of things that we're going to talk 11:37 about, because it reflects on that time, I think?

CHAIRPERSON: Could I just say this? If we're going to go into witness's health at any stage, we ought to go into a closed session.

MS. BRIGGS: Yes, Chair. 11:37

CHAIRPERSON: So I'll leave it with you.

MS. BRIGGS: Thank you.

CHAIRPERSON: It's just not right to discuss - if there are health issues then I don't think that should be on

the public transcript.

MS. BRIGGS: You're saying here at paragraph 41 at the bottom of page 12, okay, you're saying that:

"When I look back as to why I left the role at Muckamore, the lack of support..." 11:37

A. Yeah.

141 Q. Was part of that decision. Now, take your time. In what ways do you feel that you weren't supported? 11:37

A. Okay. When I first went into Muckamore, I had -- I was asked would I consider it to make changes or whatever. [Witness is upset and crying]. Sorry. But...

CHAIRPERSON: Just take a deep breath, take your time. It's always difficult. 11:38

A. No. Right, right, right.

CHAIRPERSON: And have some water. And if you want a moment, of course you can have a moment.

A. Sorry. It's fine. Sorry. I'll be all right. Sorry. Ehm, when I first went into Muckamore I went in to help 11:38 basically, and I had, I had the Co-Director of Learning Disability on one side, I had Mr. -- I'm trying to think of his name. Sorry about this. H351, he was part of Estates. I had 2 ASMs - 3 ASMs. I had - yes, I had 3 ASMs all in front of me, plus I had the two 11:39 directors behind me, I had all the wards, and the Ward Sisters, and I can't remember everything, but by the time I finished I was on my own with 1 ASM, and it was too big a job.

142 Q. MS. BRIGGS: Too big a job and too isolated. Okay?
A. Couldn't keep your eye.
143 Q. Sorry?
A. Sorry. You couldn't keep your eye on everything. Ehm, I don't know whether the quality - I didn't see any of it - I don't know whether the quality of care was good, wasn't good. I do know what I know, which was everything was, you know, we were working towards it, we were working fine, I was doing my best, and it just - obviously I wasn't seeing what I should have seen, but that was what I was being told. Also, I felt I was maybe dropped in it, if you understand my meaning? Because everybody else left and retired.. 11:40
CHAIRPERSON: Sorry, I didn't catch that?
A. Retired. Everybody else left around me and retired. 11:40
CHAIRPERSON: Yes.
A. So I was left. Ehm, and I kept going and kept going, and I didn't feel I was supported. I was there as a dogsbody at that stage. I know that sounds awful, but... 11:41
144 Q. MS. BRIGGS: There are only two things that I want to ask you about before we finish up here. The first is when you were asked to look at CCTV?
A. Yeah.
145 Q. Okay. This is at page 13, paragraph 42, and it goes through to paragraph 45. Ehm, to summarise what your statement tells us, and it tells us in detail that you were asked to look at CCTV by H296 and the Director of Nursing, and you describe in a lot of detail that's 11:41

very useful to the Inquiry about how you didn't feel comfortable doing it?

A. Mhm-mhm.

146 Q. And you didn't want to do it?

A. No. 11:41

147 Q. And you felt that you didn't have experience with MAPA. And your evidence earlier was that you weren't MAPA trained at this point. Did you get your MAPA training after?

A. No. 11:41

148 Q. Okay. Have you ever had MAPA training?

A. No.

149 Q. No. Okay. You describe telling H296 and the Director of Nursing that you didn't want to review the CCTV, that they wanted you to do it, and you say that you 11:42 found the reviewing very stressful and eventually you left Muckamore. It sounds as if, when you read those paragraphs, that you were being pressured into doing something that you didn't want to do because you didn't feel it was perhaps appropriate to do, or you weren't 11:42 perhaps qualified to do it, is that fair?

A. I wasn't qualified to do it. I hadn't a clue. I didn't know what it looked like. I didn't know what I was looking at. It was, you know, it was black and white. That's all I know. I'd never been through a 11:42 police station in my life, never mind going in to look at other people's, you know, I couldn't see, I couldn't see what they were doing.

150 Q. Do you know why it was you were chosen to do that task?

A. I had not a clue. I didn't go in looking that role. If I had have thought that was going to be involved, I would never have done it. I was -- as far as I was concerned -- maybe the fact that the Co-Director had retired and then they thought I would be able to pick up on things like that there. But, no, I don't know why. And it was -- that I was very unhappy with. That was the last straw.

151 Q. The final thing I'd like to ask you about before I pass over to the Panel is an opportunity to comment on a criticism that was put to you when you prepared your statement and you were given the opportunity to respond to that criticism. I'm going to read that out into the record, and your response to it, and if there's anything that you want to add, you can do so. I'm just going to read for a moment, and that's paragraph 47 on page 14, and it goes through to the end of your statement. It reads as this:

11:43

11:43

11:43

"I have been referred to criticism made against me by A4 and I wish to take this opportunity to respond. Firstly, I am answering these allegations from memory, as the can criticisms relate to five years ago. I retired from the Belfast Trust in 2023 and I have no access to records or documents. I refute all the allegations/criticisms made by A4.

11:44

The Inquiry provided me with a summary of the

criticisms made by A4. The summary reads:

"The Witness A4 alleged as follows:

You attended a meeting with A4 in respect of a decision to refuse to readmit a patient who had been discharged on trial basis to supported living in 2019. During this meeting you directed A4 to change the patient's legal status from detained patient to guardianship. You told A4 that this was on instructions from the director. A4 did not believe that the director had given this instruction. A4 knew this could not be done and, therefore, refused to change the patient's status. You responded by pointing your finger at A4 in front of junior staff and a care provider during the meeting. A4 e-mailed you to follow up on the meeting, but you did not reply." 11:44 11:44 11:45

And your response is this, you say:

"The summary the Inquiry provided to me states that A4 e-mailed me to follow up on the meeting, but I did not reply. The summary provided aligns with A4's witness statement. In A4's oral evidence to the Inquiry on 14th November, A4's evidence on this differed." 11:45

- and you point out how. You say that: 11:45

"A4 stated I sent an e-mail to several members of junior staff just expressing my concern. When asked by Inquiry counsel if there was a response, A4 replied

"no". Therefore, in A4's statement, A4 said A4 sent an e-mail to me, but in A4's oral evidence A4 said that they sent an e-mail to several members of senior staff. It is not clear to me if the e-mail to me was the same e-mail sent to other staff or if A4 sent one e-mail to me and another e-mail to other staff? If A4 can provide the Inquiry with the e-mail or e-mails they were referring to then I would be grateful to be given the opportunity to consider this." 11:45 11:46

You say:

"I do not recall the meeting. It is possible I raised the possibility of changing the patient's status from "detained" to "guardianship" or I may have indicated what the wishes of the Director were, but I would not have directed for the patient's legal status to change. I knew a change of status from detention to guardianship was a decision only the patient's responsible medical officer could take. Beyond this, as I cannot recall the meeting, I cannot comment on what, if anything, I said in relation to the Director. However, if the allegation is that I deliberately misled people at the meeting, or deliberately misrepresented something, then I categorically deny this. I would not have done this. 11:46 11:46

In terms of resettlement generally, some staff wish to have the long-term safety net of being able to re-admit

patients in and out of the hospital. Whilst this was understandable and necessary in some cases, it could be unfair on the patient and on the families. My view was that it was much better to have full and proper assessments of the needs of the patient completed, and if a placement did break down, to examine why the placement was not working and what alternative provision could be made to support the patient to remain in the community setting. 11:47

In relation to the allegation that I pointed my finger at A4, I refute this entirely. This would not be something I would do. I can only assume A4 has misinterpreted my hand gestures, perhaps when I was trying to emphasise a point I was making. I apologise if I made A4 feel not listened to or uncomfortable. I would never wish do this." 11:47

So, H294, that's a really comprehensive response, if I say it myself, to the criticism that was made of you, but I do want to give you the opportunity, having heard me read that out, if there is anything you would like to add to that? There may not be. 11:47

A. I wouldn't -- I know I would never have asked her to change that. I couldn't do it. So why would you, you know, do it? I do feel, as I said earlier, that in some instances when people go out into rehab and it's working, why do they -- you know, in my head, you know, why do you want to be still a detained patient within 11:48

Muckamore? Why families would want that, you know, instead of "Yes, I'm living out here"? Plus, if they needed to come back into hospital, it was, you know, a complete new re-assessment of the person's needs, which may have changed and things like that there, you know. 11:48
It's not after a couple of weeks, this would have been three months/six months down the line, you know. Everything changes. So I mean it would have been - to me it would have made a lot more sense that the person isn't going in and out of hospital. It's very 11:49
unsettling for a patient going in and out of hospital whenever things go wrong. I would rather go out to the community setting and say "Right, how can we work this? How can we make this work?" Or "Do we need another person to help out? Do we need?" -- and if it wasn't 11:49
going to work, that's fine.

CHAIRPERSON: Slow down. Just slow down a little bit.

A. Oh, slow down. Sorry. Right. Okay. It's just, you know, I would have -- but I wouldn't have been directing her, definitely not, to change anybody's 11:49
legal status. It's not...

CHAIRPERSON: Although are you saying that that would have made sense to you?

A. It would have made sense that, you know, if the person -- I can't remember the meeting, but I know if it was 11:49
me and if somebody had been out in the community for six months, why would you, you know, in my head, why would you want to be classed as a detained patient?

CHAIRPERSON: Right. Okay.

A. If things are working. I think it was more a safety net for the social work team than it was for the patient, that they could get them into Muckamore, you know, if things --

CHAIRPERSON: Because the difference, just so that I understand it, the difference would be with a detained patient, if the resettlement fails it's easier to get them back into Muckamore than if they're under a guardianship order, is that right? 11:50

A. I honestly -- my view was that if they are a detained patient they can come in and out without a complete assessment, new set of assessments and things like that. Whereas, I would imagine after six months or whatever, you know, you would have given them additional time even if they had been settled. That would have made far more common-sense than, you know. But this person was settled - that I can think, that this is what has been going on, that they had been settled, and they just wanted that assurance that they could hop into the hospital if they needed, you know what I mean? 11:50 11:50

CHAIRPERSON: Okay.

A. It's not really - it's not fair on the patient, it's not fair. Rather than work out in the community.

CHAIRPERSON: Thank you. 11:51

MS. BRIGGS: H294, that's all the questions I have. The Panel might have some more?

A. Okay.

CHAIRPERSON: No. Can I thank you for coming to give

evidence to the Inquiry. It is sometimes harder than people think once they get here and they start remembering things. But I do want to thank you very much for coming along to assist us, as you have done, and I'm now going to invite you to go with Jaclyn who will look after you. So, thank you.

A. Okay. That's all right. Thank you.

CHAIRPERSON: All right.

A. All right. Okay. That's lovely. Thank you. 11:51

THE WITNESS THEN WITHDREW

CHAIRPERSON: I think we've got some reading to do.

MS. BRIGGS: Yes. Ms. Tang has some reading to do.

CHAIRPERSON: Can we go straight into that? 11:51

MS. BRIGGS: I think so.

MS. TANG: Good morning, Panel.

CHAIRPERSON: Good morning.

MS. TANG: I'm going to be reading in the statements of two staff members. The first statement is page reference STM-317, and that is the statement of Suzanne Smith, dated 27th August 2024, and there are three exhibits with the statement. I'm going to read most of the statement into evidence and, where possible, I will summarise some of the paragraphs. 11:52

CHAIRPERSON: Sure. But in fact this is, I think, the first statement of this particular discipline that we've had. Have we had another SALT?

MS. TANG: I think there may have been one.

CHAIRPERSON: She's a SALT? Speech and language therapist.
MS. TANG: Speech and language therapist, yes.
CHAIRPERSON: Yeah. Well, we haven't had much evidence certainly about speech and language, so let's have it. 11:52
MS. TANG: No, that's correct. That's correct. Yes. Okay.

STATEMENT OF MS. SUZANNE SMITH - REFERENCE STM-317 READ BY MS. TANG

MS. TANG: The statement begins:

"I, Suzanne Smith, make the following statement for the purpose the Muckamore Abbey Hospital Inquiry. 11:53

My connection with MAH is that I worked there as a speech and language therapist. The relevant time period that I can speak about is between September 1994 and September 2022." 11:53

The witness then provides some paragraphs 3-7 where she summarises her education and her early career in various different roles in other organisations, and I want to pick up at paragraph 8, please: 11:53

"It was some time ago, but I recall that initially I spent around one day per week in the community working with children, two days per week working with adults in

the community, and spent two days per week at MAH. I had no friends or family who worked in MAH when I started.

I did not work in the community with children for very long. I think that I did have a line manager at MAH and a different line manager for my community work. I have general SALT training, which included working with children and adult patients who have learning disabilities." 11:53 11:54

At paragraph 11 the witness describes taking some time out to have a family, and then picking up at paragraph 12:

11:54

"My roles and responsibilities in MAH consisted of the assessment and treatment of communication and eating and drinking difficulties in adults with learning disabilities. I carried out SALT assessments of patients following referral to the SALT service. 11:54 My workload came around through referral rather than allocation. Ward staff and day care staff made referrals in respect of any patient they felt required assessment. The referrals were normally made by the named nurse, however on occasion the referrals were 11:54 made by more senior nurses on the ward. All referrals were made by qualified staff. The referrals were initially by way of a paper referral being completed, which was then acknowledged and entered into a referral

book, and then over time this process was replaced by an electronic referral system.

I oversaw work of a SALT assistant and some junior SALT staff. Over the years I attended many meetings mostly in relation to patient care. I attended many ward reviews and ward meetings, admission meetings and discharge meetings, as well as meetings set up to discuss particular aspects of particular patient's care, often attending to get multidisciplinary team agreement on a course of action or treatment with regard to the management of eating and drinking difficulties. I did not have any responsibility for monitoring ward staffing, ensuring compliance regarding patient property and finances, and monitoring length of stay, discharge and resettlement plans." 11:55 11:55 11:55

The witness then provides some details of the line management that she was under in paragraph 15, and picking up paragraph 16: 11:56

"I would say that in general, different wards had different cultures, and this culture also varied over time as different staff worked there and managed the wards. In the early years most SALT work was done within the day care building rather than the wards. I would not have been on the ward unless I was there following a referral. Some wards made more referrals than others. I received more eating and drinking 11:56

referrals for patients on wards where the care was for patients with greater physical difficulties. On other wards patients had difficulties with communication. It really varied what referrals came in for each ward. On Greenan and Rathmullan Wards, for example, I carried out a lot of eating and drinking assessments and provided a lot of guidance, whereas on Six Mile, Fintona North and Fintona South Wards, the patients were physically well and I received relatively few referrals from those words. 11:56 11:57

In the earlier parts of my time at MAH I worked with patients while they were at day care in the day care area. I did this as there were fewer patients in each room and there were more opportunities to promote communication, and it was generally more spacious so I could do group work with patients. 11:57

In relation to being asked about atmosphere on wards I would say that the atmosphere varied over the wards and over the years, but I was always made welcome on the wards and treated with respect. I felt that the staff on most wards preferred that times of my visits were prearranged and agreed. I rarely went to see a patient on any ward without first checking that the time suited the staff and patient. In the early years I never had keys to wards, which meant that I had to wait to be let in. SALT were only issued with fobs to access wards around 2020, to coincide with Covid infection controls. 11:57 11:57

Even when I had a fob to allow access, I telephoned the ward before going to check that it suited the staff and patients for me to be there. I felt that my advice was appreciated by the ward staff. I sought updates in relation to treatment and may have been asked to provide further guidance. I provided feedback where recommendations and advice had not been adhered to. Overall I felt I had built up a good relationship with the staff on a number of wards. As I described earlier, there were particular wards that I was on more frequently so I developed a greater rapport with staff. I did not feel that there was ever resistance to me, my presence, or my work. 11:58 11:58

I observed that MAH ward staff were in the main very good at following SALT guidance relating to eating and drinking requirements and as a result we had very few incidents." 11:58

The witness then goes on to summarise some of the guidance, the guidance rule that she would have had. 11:58

I want to pick up at paragraph 22:

"I think generally speaking staff worked well together. As noted previously, staff generally treated me with respect and valued my advice and adhered to advice given by me regarding eating and drinking difficulties. Staff did their best to carry out work on any therapy 11:59

goals I had requested. It can be difficult for the aims of therapy to always be communicated to everyone on a busy ward, but staff did their best with this."

And from paragraphs 23 onwards the witness then goes on to list examples of good care that she witnessed or was involved in. 11:59

Paragraph 24 deals with personal place mats that she created to assist patients. 11:59

Paragraph 25 refers to use of the safety pause, and the witness states that:

"This was training that I provided for all staff. It was part of a "Safe-tember" campaign one year. During training and with the use of the place mats I realised it was hard for staff to have an overview of the ward and all the patients on the ward. We created sheets for the back of the office door on the ward so that staff could pause at meal times to ensure that food and drinks of correct consistencies were being provided and that other recommendations were also in place." 11:59 12:00

And the witness then goes on to provide some information at paragraph 26 about talking mats, which were developed to aid patient communication. 12:00

In paragraph 27, participation in arts and disability

awards.

And in paragraph 28 Easyread information, and I'm going to pick up at that point:

12:00

"Easyread information was something that I provided for many patients to help them understand many activities or things which were to happen in their lives. I created bespoke social stories for patients, such as moving to a new home, to help aid resettlement. I also 12:00
used bespoke social stories if patients were attending acute hospitals for investigation to try and help patients to understand this. In addition to this, many social stories and Easyread resources were provided on generic topics for patients over the years, for 12:01
example, related to Covid, flu injections and health screening. In relation to Covid, for example, I had to break the language down to explain what it was and the implications for patients. I had to explain why we had to sit apart during visits and why patients had to talk 12:01
to their parents on the telephone."

The witness then goes on to describe some of the techniques that she used to assist in communication. I want to pick up just a sentence beyond that at: 12:01

"I recall a SALT colleague taking the lead in relation to explaining CCTV using social stories and Easyread information. Again, in relation to explaining anything

complex which was to happen to patients, the other speech and language therapists and I would drill down the basics of the concept. We would try and remove ambiguity and try to use easy to understand vocabulary, short sentences, and simple grammar. For example, avoiding negatives. I do not remember specific aspects of the CCTV communications as we created so many social stories and so much Easyread information. Upon reflection I do think it would have been a challenge to explain that the images of what was happening in one place could be seen in another, as many patients found it difficult to understand abstract concepts such as this. 12:02 12:02

We worked with stakeholders to create and quality assure this information, including patients via the Tell It Like It is group and the Association For Real Change. I recall explaining the Mental Capacity Act and capacity to patients. As part of this, I used Easyread information and actual locks and keys and other props to help with patient understanding. 12:02

When a patient had to have dental work, I did, on occasion, obtain the actual items that were going to be used as part of the treatment and would have shown and demonstrated these so that the patient was familiar with what was going to happen. By way of example I have attached at Exhibit 3 a social story about moving to a new home." 12:03

The witness then provides at paragraph 29 some information about a sensory story project.

At paragraph 30, some real-time patient feedback, which was a project she was involved in. 12:03

Therapy boxes are detailed in paragraph 31, and church service participation in paragraph 32.

12:03

I want to pick up at paragraph 33:

"Within SALT I cannot think of examples of poor care that I provided or witnessed. I feel that our resources within SALT were limited and time in MAH was limited. I and other staff were unable to always do as much as we would have liked. Our resourcing wasn't what we wanted it to be. If I could have been at more review meetings that would have been better for patient care. I had three day centres and was part-time, so I had to prioritise my time by seeing patients. I did not witness anything about which I felt uncomfortable. 12:03 12:04

In the later years SALT were usually invited to an admission meeting, but in early years when SALT input was more limited we were not able to attend. We did however usually ask what the reason for admission was if a new patient was admitted. 12:04

If I attended the admission meeting and if the patient had a previous SALT input, I would have tried to get information on communication and/or eating or drinking difficulties from the previous SALT.

12:04

If I attended the admission meeting I might have been aware of the risks each patient posed, but I would have generally asked about risks before seeing a patient when triaging a referral with a member of ward staff."

12:04

The witness then provides some details about the approach to patient-centred care that she provided and some work that she did to improve meal time experiences called "Meal Appeal".

12:05

I want to pick up at paragraph 40:

"In terms of liaison with families, I and the other speech and language therapists liaised with many families, especially those patients with serious eating and drinking difficulties. In the early years I do not recall ever attending admissions meetings, but in later years did I participate in meetings called "Purposeful In-Patient Assessment", which was abbreviated to PIPA, and admission meetings linked in with these.

12:05

12:05

Following admission, patients could be referred to me. I assessed the patient and provided ward staff with a report on my recommendations and a care plan. I

supported parents and provided them with an opportunity to contribute to personal place mats. If a patient required further investigation of swallowing, I arranged video fluoroscopy study of swallowing, VFSS. As part of this I liaised with the patient's parents and family and encouraged them to attend the appointment. I accompanied the patient and the family to the appointment. 12:06

I ensured that all SALT communication interventions were typed up as a care plan and this would have been reviewed after an agreed timescale, for example, three or six months. If the goals had been met, I would have liaised with the ward and day care staff about next steps, which were often to broaden these goals or extend them to other environments. 12:06

I was not involved in auditing ward records, but I understand our care plans and documents were audited as part of the normal ward processes by normal ward staff. 12:06

Eating and drinking recommendations were also devised and typed up, but these would not have been specifically reviewed by SALT, unless this was requested, as recommendations in this regard were often more straightforward. For example, thickening of liquids or modification of a diet to a certain consistency. 12:06

I would have considered various aspects of a patient's care and their health and any particular vulnerabilities as part of my assessment. For example, I would have considered chest status, chest and urinary tract infections, and would also have considered risks such as dehydration, aspiration and choking risk.

I would only have been on the ward and involved in meal times when I was carrying out a patient assessment. I always felt that meal times were strictly controlled. For example, televisions and radios would be switched off. The safety pause was used, and if staff were not needed on the ward for the delivery of meals they were not allowed on the ward. There were specific members of staff allocated to supervise meal times and these would have been qualified nursing staff. I cannot recall the name that was given to the specific person supervising meal times.

I was clear about what restrictive practices were and when they were able to be used. I was not involved in using restrictive practices. I did have a single day of breakaway training, but this was to ensure that I was able to remove myself from any risk rather than as a restriction for patients. I was not involved in the recording or the use of restrictive practices. I was not involved in the administration of medication, such as PRN medication. I was not involved in the use of seclusion.

When a patient was becoming distressed I may have become involved in managing that patient. I did this by sitting with the patient and trying to calm them by being a reassuring presence. For example, using a soothing tone, using fewer words, and communicating via body language, such as stroking the patient's hand. I may have been involved in communicating with the patient after an incident or restrictive practice was used and explaining what had happened and why. For example, I recall on one occasion, although I am not sure when this was, I did an Easyread and social story for a patient to explain why one of the other patients had been restrained." 12:08 12:08

The witness then goes on to provide some supervision that they provided to an unregistered assistant and to detail some engagement that the witness had with families. 12:09

I'm going to pick up with 49:

"If a family were visiting and I was on the ward, I engaged with them and might have updated them on what SALT was doing with their family member, if they were keen to hear about this or if it was appropriate at that time. 12:09

I did not have a role in managing the merger of wards,

save for explaining to patients the changes that were happening. I recall, for example, one patient who was particularly concerned about his personal items, including his PlayStation. I was involved in engaging with him to explain that the names on his PlayStation would be saved and that the new ward would also have Wi-Fi so he could play it.

I was involved in supporting patients to understand the process of resettlement and make decisions around it. I shared information about patients with relevant new staff. I was also involved in some training for staff in new facilities. I made sure that the new facility was aware of a patient's requirements around things like meal times. I had a dual role in communicating with the staff in the resettlement location, but also communicating to the patient. The later resettlements involved staff members from the resettlement facility coming to MAH to observe the patient and understand their needs. I ensured that I passed on to them the patient's likes and requirements. I did as much as I could to support the patient's own understanding of the resettlement. I used a lot of books to explain things, such as the patient's new bedroom, their bathroom, and the drive up to the new resettlement. In later resettlements where I was more involved I would have gone out to the patient's new home to try and ensure that the resettlement was successful and to say goodbye. The occupational therapist and I often did

12:09
12:09
12:10
12:10
12:10

this together. I feel that it was important for our patients to mark the end of their time at MAH. I also feel that it was important for patient's families that we communicate the end of their time at MAH and share with them our referral details and any stories." 12:11

The witness then goes on to provide a little detail of RQIA inspection visits and being able to speak to an RQIA Inspector. 12:11

I want to pick up at paragraph 54:

"It is difficult for me to comment on whether doctors, members of senior management and the BHSCT Board Members were present on the wards during my early years as I was on the wards less often. I worked more in day care areas. In later years, especially since the introduction of PIPA meetings, doctors seemed to be there very regularly. 12:11

I do not remember much interaction with senior management or Board members at MAH. The only interactions I had with them centred around the talking mats, which received good feedback from them, and around award ceremonies. I recall on one occasion having a tea party which was attended by senior management and patients. 12:12

If a SALT member of staff was assaulted I would have

supported the staff member to come back to the SALT department, take a break, assess and treat any injuries, go home if needed, and complete a Datix report. While I do recall that assaults happened, I do not recall in detail any particular incidents. I recall one assistant who asked to be redeployed. I engaged with Human Resources to help facilitate this redeployment from MAH to another learning disability post. I believe that MAH was not for her as she had health and other issues. I would prefer not to give her name. I believe that SALTs were not assaulted as frequently as we were not on the wards or in day care as much. 12:12 12:12

I reviewed the frequency with which SALT staff were involved in incidents. I felt that I could speak out or report to management any issue about which I felt uncomfortable. I do not recall receiving any complaints about care at MAH or complaints about me or any of the other SALTs. I would have contributed to meetings where families had made complaints." 12:12 12:13

The witness provides detail of her line management, her own line manager, in paragraph 59.

12:13

I want to pick up at paragraph 60:

"I was made aware of the introduction of CCTV when SALT were asked to provide an Easyread document to share

with patients. I think there was also an e-mail that was circulated to us. I do not remember patients being very impacted by the introduction of CCTV. As described previously, I am not entirely sure how well the patients I was working with understood CCTV as a concept. Images being captured one day then watched at a later date is challenging to explain to patients in a way that they understand. Images being captured in one place and then viewable in another place is also difficult. My role was about helping people to understand, and I used all the tools I could and the recognised and recommended methods. 12:13 12:14

I do not feel that the introduction of CCTV changed how staff behaved. 12:14

In the Speech and Language Therapy Department we all did our best to support the patients that were in MAH. I think that multidisciplinary working was something we were very good at. The Allied Health Professionals at MAH all worked well together, and I considered them all friends. I felt that I could knock the door of the dietician, for example, and get some advice and chat with them. I was deeply saddened to learn of the allegations which have given rise to the creation of this Inquiry." 12:14 12:14

The witness then provides her usual indications about giving evidence, et cetera, and I should note that

there are three exhibits that are with the statement. The first is a personalised place mat when she has referred to in her statement, and then there's an example of talking mat, and finally there's an example of a social story. 12:15

CHAIRPERSON: Yes. And it's very useful to see those. Thank you. All right. Well, thank you to that witness. I don't know if she's watching, but thank you for the time taken to produce that statement. We can move on to the next one. 12:15

MS. TANG: Yes. Thank you, Chair. The next statement is from staff member H298, and it is dated 9th April 2024.

CHAIRPERSON: Can I just say in relation to this witness, that we've given very careful consideration to allowing this statement to be read, because in other circumstances we would actually have wanted this witness to come and give evidence. But there are personal circumstances relating to the witness that has persuaded me that it is appropriate for this statement to be read and not to require her to come here to give evidence. 12:15 12:15

MS. TANG: Thank you, Chair. As with the previous statement, I will be reading in most of the statement, but where possible I will summarise some paragraphs. 12:16

STATEMENT OF H298 READ BY MS. TANG

MS. TANG:

"I, H298, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement.

12:16

My connection with MAH is that I worked there as a nurse at various grades from 1992 until 2022. During my time at MAH I worked as a trainee nurse, a Staff Nurse, and then as a Deputy Ward Sister.

12:16

The relevant time period that I can speak about is from 1992 to 2022."

And the witness then provides some details of her early training, and that she is from another part of Ireland, 12:16 and she confirms that she did not have any family who worked at MAH during the 30 years that she was there.

I want to move on, if I can, to paragraph 4, please:

12:17

"I qualified as a learning disability nurse in 1992. I worked as a Staff Nurse, Grade D, now known as a Band 5, in various wards in MAH over the years. I was first appointed a temporary Staff Nurse post in MAH for six months. It was difficult back then to get either a 12:17 temporary or permanent post in MAH as everyone wanted to work there.

When I first started working in MAH in 1992, it was

very different to what it is now. There were over 800 patients in the hospital and it had a community village feel about it. It was a very large and busy site. I remember thinking on my first day in MAH "I'll never find my way about this place." I remember thinking there were over 20 wards at that time, along with numerous day care buildings, office buildings, a swimming pool, a hairdressers, a pharmacy, a dentist, a transport department, a shop, and a large canteen. 12:17

12:18

After my temporary post for six months I was given a permanent post as a Staff Nurse at MAH. When you moved wards in MAH it felt like you were starting a job, because the needs of the patients varied so much from one ward to another. The remit of these wards to care for people with varying degrees of mental health and learning disabilities and they were categorised into areas such as: care of the elderly, challenging behaviours, admission wards, forensic wards, and children's wards, for example." 12:18 12:18

And the witness then goes on to provide some details of a six-month placement in Ennis Ward and some time working in Birch Hill Bungalows between '93 and '96.

12:18

I want to move to paragraph 8:

"After my time in Birch Hill, I was transferred to the Fintona North Ward in MAH in approximately 1996. I

worked in Fintona North as a Staff Nurse Band 5 for approximately seven to eight years. This was a female admissions unit. There were 18 to 19 beds on this ward. Fintona North was a challenging ward to work on. Some staff within the hospital did not want to work on this ward because of the challenging behaviours of the patients and the level of violence displayed to others by the patients. The patients on this ward had varying degrees of learning disability ranging from severe to mild, often coupled with autism and superimposed mental illness. This led to higher levels of violence, and aggression, and conflict, due to incompatibility issues between patients. 12:19 12:19

On this ward there were also patients who were detained under the Mental Health (Northern Ireland) Order 1986, which meant that they needed to stay in hospital for a period of assessment and treatment. Some patients resented having to be in hospital. 12:19

The environment on Fintona North was not great compared to the new buildings which succeeded it. Fintona North was an old ward built in the 1950s, and I believe the environment was a contributing factor to the patient's exacerbated behaviours at that time. The ward was composed of two large day areas, dormitory with 12 beds, six single side rooms, visitors rooms, a large bathroom and toilet area, which was a shared space. Clinical room, laundry room, garden and courtyard. 12:20

Environmentally resources were limited in those days, with patients having a lack of space and privacy, but staff tried as best they could by supporting patients to have time off the ward, attending various recreational activities within the hospital grounds and the wider community setting.

There were many activities available to patients within the hospital at that time. I recall there being an entertainments officer who organised activities and social events for the patients on daily basis.

Prior to admission to Fintona North, the patient's behaviour would often have caused fear in the local community due to an increase in violence and aggression. This would have led to the patient's placement breaking down, because at that time there was very little infrastructure to support people with learning disabilities who were in crisis in the community. That is usually why they ended up being admitted to MAH, because they were in a crisis situation. The nurse in charge of the shift would have managed any new admissions to the ward. It was not their decision to admit a patient. This would have come from a referral from a GP or a social worker who would then have discussed the admission with a consultant psychiatrist. The patient's next of kin would have been kept updated of the pending admission to hospital, either by the ward social worker or

nursing staff in MAH.

At the point of admission, the nurse in charge of the shift would check all the detention forms were filled out correctly, particularly for legal detentions under the Mental Health Order. Prior to a patient's admission there would have been a pre-admission summary completed by the medical staff. There was good oversight of detentions within MAH. This was done through a process of detention forms being checked by the medical records staff. MAH had very good medical records department, staffed by medical record secretaries who were excellent in informing us and helping us understand the Mental Health Order. At the point of admission, information in relation to the patient's needs would be obtained from the patient, their relative or carers. The social worker also informed the assessment. There was usually a post-admission meeting within two weeks of the patient's admission. 12:21 12:22 12:22 12:22

Patients could also come into MAH on a voluntary basis. If they did this, it was assessed that they could have understood the process based on their IQ and understanding in the interview conducted by the medical staff in MAH. Formal written capacity assessments followed in later years. Patients who were voluntary patients would have had higher IQs than those admitted on a detained status. Sometimes a voluntary patient 12:22

would change their mind and want to leave MAH. However, there was a process in place that prevented them from leaving immediately to maintain their safety and the safety of others. If it was assessed that the patient was at serious risk of harm, the patient would then be detained under the Mental Health Order. The senior medical registrar would complete a mental state assessment of the patient and determine if they could leave safely or if they had to stay for the whole assessment period under the Mental Health Order. If the patient was deemed not to be a risk to themselves or others, they would have been able to leave the hospital." 12:23 12:23

The witness then goes on to outline a little bit of her Band 5 nursing role and give detail of the named nurse system that was in place, and of her time, her positive experience on Mallow Ward. 12:23

I want to pick up at paragraph 16, please: 12:23

"I always had support from other professionals, such as the psychiatrists. The consultant psychiatrist could have had responsibilities for approximately two to three wards. They had a lot of knowledge they would share to help care for patients. I could always get advice on patients from the consultant psychiatrist and psychologists as well. The focus for the patients on Mallow Ward was all about "creating a new me". This 12:24

included involving patients in activities, such as horticulture, wood work, socialising, and some of the patients went to the local technical college to learn new skills. The patients were always accompanied by a nurse or nursing assistant. It did not always need to be a registered nurse, but just someone who knew the patient well. If we were taking a patient off-site out of the hospital grounds and they were detained under Part 3 of the Mental Health Order, we had to get permission from the Northern Ireland Office. On this ward we worked closely with MASRAM (Multi Agency Sex Offender Risk Assessment and Management) and in later years PPANI (Public Protection Arrangements in Northern Ireland), the Police Service of Northern Ireland, the Probation Service, and the patient's owning Trust, to maintain the safety of the public. There would have been regular meetings regarding the patient's risk management plan. As a patient's named nurse I would have been involved in these meetings. I do not recall specifically how often these meetings occurred. 12:24 12:24 12:25 12:25

Up until 2008 approximately, there were no dedicated adult safeguarding forms to complete. Adult safeguarding referral forms did not come into the hospital until approximately 2008. If there was an incident or a complaint, for example, if two patients did not get on with each other and were involved in a conflict, it would have been recorded on the patient's care plans and discussed with the doctor. Typical 12:25

complaints raised by patients would have been that other patients stole possessions belonging to them, or there may have been differences of opinions amongst patients, for example, arguments about football, which led to fallout between patients. Complaints such as these were normally daily business and usually resolved locally without going through a formal complaints procedure. More serious complaints and incidents would have been escalated and reported to the MDT and senior management. The regional adult safeguarding procedures followed in later years, in which staff received regular training which later became mandatory training. 12:25 12:26

In 2008, the Mallow Ward closed and all the patients transferred to the new Six Mile Ward. This was the start of the new hospital. Prior to the new wards opening, all staff were kept up to date on progress with staff information sessions. Previously forensic male patients would have gone through the general male admission wards of Movilla A and Movilla B and then been transferred to the Mallow Ward. The Six Mile Ward was the new male admissions ward and treatment ward for forensic mental health and I would have been involved with the patients on this ward from the very start. 12:26 12:26

The focus on the Six Mile Ward was more on forensic nursing. Forensic nurses provide specialised care for patients who have come in contact with the criminal justice system who require in-patient hospital

treatment rather than receiving a prison sentence. The patients who were admitted to this ward had committed more serious offences and had convictions such as murder, manslaughter, arson and rape. When I moved to Six Mile it was a requirement for all staff to have 12:27
experience in forensic mental health and specialist training in the fundamentals of forensic nursing was provided to us through the University of Ulster. The Six Mile ward was to be a dedicated forensic service for people with learning disabilities. I recall that 12:27
the hospital employed a forensic psychologist, H258, who had previously worked with the Prison Service and brought a lot of knowledge and skills with her in relation to a treatment programme for offenders. H258 carried out various treatment groups with the patients, 12:27
i.e. the Adapted Sex Offenders Treatment Programme. Which was devised by the Prison Service and implemented in MAH, and the New Me Treatment Programme, to help patients develop a pro-social identity and plan for an offence free live. These treatments were supported by 12:28
the nursing staff on the ward.

When I worked on Six Mile I worked as a Staff Nurse Band 5 with a nursing team of other registered learning disability nurses and nursing assistants. There was a 12:28
charge nurse, H13, and a deputy change nurse, H369, both of whom were learning disability nurses. Every patient on the ward had a named nurse. The atmosphere of the Six Mile Ward was positive, both for staff and

patients, due to low levels of violence and aggression. Six Mile was a new building and its environment was very patient-centred and met the needs of the patients."

12:28

The witness then goes on to describe some of the features of the new ward and some of the facilities that were available for the patients.

I'm going to pick up at paragraph 20: 12:28

"I recall when working on Six Mile that the discharge process for patients was very slow and did not happen quickly due to the nature of the patients and the offences they had committed. There were few community 12:29
facilities to manage the risk behaviours of these patients. I would I have worked with the MDT and In-Reach providers to help identify suitable community placements for patients. The patients owning Trusts would also have contributed to this process as they 12:29
would have been responsible for funding the placement. I always felt that I adequately assisted with the discharge needs of patients as I had my own first-hand knowledge of the patients and their needs and could advocate on their behalf for a suitable placement. 12:29
There was, of course, emphasis placed on the protection of the public during the discharge processes of patients from Six Mile, due to the risks these patients presented."

The witness then goes on to outline that she was promoted to a Deputy Ward Sister in the PICU Ward. Picking up at paragraph 22:

12:29

"In 2012 I took up the post of Deputy Ward Sister, Band 6, in the PICU Ward, which was Psychiatric Intensive Care Unit at MAH. The environment on this ward was very different to Mallow and Six Mile and presented many challenges on a daily basis. The patients there 12:30 were a mix of male and female patients who had a diagnosis of severe autism, schizophrenia or personality disorders. The main purpose of this ward was to provide increased observation of patients. There was six bedrooms on the ward for individual 12:30 patients, individual quiet rooms for patients to use, as well as a seclusion area, which included a seclusion room with a bed and access to toilet and shower facilities. If patients on other wards began suffering from severe mental illnesses, for example, 12:30 schizophrenia, bipolar disorders, or were becoming increasingly more disturbed, they would have been moved on to PICU for increased monitoring of their condition.

In 2012, PICU was initially an annex of the Cranfield 12:30 Women's Ward, and I reported to the Ward Sister for Cranfield Ward for a short time, until a new charge nurse was appointed to PICU. At that time we had a full complement of nursing staff in PICU and PICU was

always to be fully staffed on each shift."

The witness then goes on to describe the change of Datix. I'll just read the paragraph, it's easier. Paragraph 23: 12:31

"During my time in PICU, the reporting procedure for reporting incidents on Datix was the same as for the rest of the wards. Datix is a risk management information system designed to collect and manage data 12:31 on adverse incidents. I cannot recall the exact date Datix was introduced. Before Datix, incidents were reported on hard copy incident report book kept on each ward, which, from memory, was sent to the general nursing office for the attention of the senior nurse 12:31 managers in MAH, and a copy of the incident was to be copied to the patient's hard copy file where the care plan was kept."

The witness sets out that she felt well trained to deal 12:32 with the patients in PICU, including having access to MAPA training.

I'm going to pick up at paragraph 25:

12:32

"However, there were times the patients in PICU displayed very high levels of aggression towards staff and, at times, other patients. I recall staff members receiving significant injuries from some patients. The

risk of harm to patients would have been reduced by interventions used by nursing staff, but I do recall patient-on-patient assaults occurring. I recall raising my concerns about assaults at professional meetings with the MDT, the patient's owning Trust and the hospital management. I recall raising concerns regarding violent and persistent risk behaviours displayed by one particular patient, P60. He had physically attacked many staff within the ward including myself. On one occasion when I was standing at the servery kitchen hatch to get a glass of juice for him, he attempted to strangle me from behind, putting his forearm around my neck and then punching me in the stomach with his other hand. My nursing colleagues responded quickly to this incident. The other patients who had witnessed this were visibly upset and were emotionally supported by nursing staff, and needed further support from psychology. I was offered counselling after this incident but did not avail of it. I did not have any time off work following this assault. However, it is one of the incidents that has stayed wit me throughout my career and causes me anxiety. P60 also attempted to attack his family during visits and his family visits were supervised by nursing staff. I felt that this patient would have needed treatment in a more secure environment, but his family did not want him to leave Northern Ireland. From my memory P60 had a diagnosis of bipolar disorder, mild learning disability, and

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autism. I felt at times the nursing staff in Muckamore were expected to manage patients who presented extremely high risk behaviours to others. Whilst PICU was a capable environment to manage risk behaviours of the general learning disability population, there were difficulties managing extreme risk behaviours and high levels of aggression. During my time in PICU, three patients were transferred to medium secure hospitals in the UK for further treatment, namely, P210, P211 and P212." 12:34

The witness then goes on to describe being moved to Oldstone Ward in 2014, and I want to pick up at paragraph 27 some details of that:

12:34

"The patients remaining in Oldstone at that time were transferred back to the core hospital wards to await community placements. I recall Oldstone would open and close here and there over the years depending on the number of patients on delayed discharges within the hospital at any given time. I think the closure of Oldstone did impact on the patient's opportunity to have access to a structured pathway out of hospital. 12:34

The final closure of Oldstone in 2016 appeared sudden and I personally asked Sharon Hanna, an advocate with Mencap, to raise this issue with senior management in the Belfast Trust, but the ward ended up closing anyway. 12:34

Decisions were made about closures of wards at MAH by senior Belfast Trust Managers, without inclusion of clinical teams. When wards closed or were amalgamated prior to the opening of a new hospital in 2008, meetings were held in advance to discuss the transfer of patients and staff. We would have also had team-building days so that staff could get to know one another before they started working together on the wards. I would say this aspect of staff support was very well handled at MAH. After 2012, there was a change in how senior management communicated with the staff in MAH. 12:35 12:35

In 2016 I moved to the Cranfield Women's Ward as a Deputy Ward Sister, Band 6. This was an adult female admissions ward. The atmosphere on Cranfield was very different to the previous wards I had worked on, in that it was a very busy environment with a high turnover of admissions and discharges of patients." 12:35 12:36

The witness then goes on to describe some of the processes and systems on Cranfield Ward.

If I can pick up at paragraph 29: 12:36

"The patients in Cranfield Women's Ward were highly aggressive towards other patients and staff. I recall one patient in particular, P4, had exhausted all mental

health services in the community and was detained under the Mental Health Order. P4 had a diagnosis of schizophrenia, personality disorder, and there was a query in relation to her learning disability. She would attack other patients and staff, break glass, threaten patients and staff. She would also have absconded MAH on a regular basis and be brought back to MAH by the PSNI, usually intoxicated after consuming alcohol and drugs. I cannot recall P4's level of observation. I do recall on one occasion that she had absconded, she had gone out to the on-site shop and ran off from the staff who tried to follow her. I cannot recall if this was reported as an adult safeguarding issue. Because P4 was a detained patient, this matter was immediately reported to the PSNI, who brought her back to MAH. 12:36 12:37 12:37

On one occasion, in or around August 2016, P4 tried to strangle me, which caused great distress not only to myself but to the other staff and patients who had witnessed it. I was able to break away from her but was hospitalised afterwards and was off work for a two month period. P4 was prosecuted and charged for ABH, along with charges of assaults on medical and nursing staff in the Mater Hospital. I did not have to give evidence in court as P4 admitted to the charges. I recall she received a suspended sentence. I received counselling through the Trust to help me cope with this significant event and to enable me to return to my job. 12:37 12:37

There was CCTV on the ward at the time, but it had only been installed and was not up and running properly and did not capture the incident.

The impact of incidents of violence and aggression over the years has had a profound impact on me, both personally and professionally, leading me to have much reflection, counselling, and a real effort to develop positive coping strategies to help me continue in this line of work. Very often in Learning Disability Services, there is an acceptance and normalising of these behaviours to avoid catastrophizing incidents. However, these incidents do frequently occur in mental health and learning disability environments, and staff who work in these environments will continue to find themselves in stressful and difficult situations." 12:38 12:38 12:38

The witness then goes on to describe how Cranfield transferred to Killead Ward and then that she transferred to Donegore Ward as a Deputy Ward Sister there until 2022, and I want to move on at that point to paragraph 35: 12:38

"The administration of PRN medications was a clinical judgment for the patient as to when it was required in accordance with the patient's care plan. The PRN medication would have been prescribed by medical staff with a clear reason for the need for administration, i.e. severe anxiety or severe agitation. A patient's 12:39

care plan would have included pro re nata (PRN) medications, which means they were administered by a registered nurse when necessary. PRN medication would have been typically administered if a patient was in a heightened state of distress or anxiety. The use of PRN was always recorded in the patient's notes and any increase in the use of PRN medication would have been discussed at the weekly MDT meetings. 12:39

I do not recall seclusion being used a lot during my time at MAH, and only in specific wards. It was used more often for patients with severe learning difficulties who were more prone to becoming aggressive or whom presented with acute psychotic symptoms. These patients were usually within the admission wards of the hospital. Therefore, seclusion rooms were only present in the male and female admission wards of Movilla A and Fintona North. When the new hospital came into being in 2008, PICU was the only ward that had a seclusion facility. There were times where a staff member spent many hours trying to de-escalate a patient and keep them at their baseline behaviour and accessing their usual routines. I cannot recall a specific example as this would have happened most days and is a standard approach when working with people with a learning disability. 12:39 12:40 12:40

There was a seclusion policy at MAH. All staff within the hospital were aware of this policy and it would

have been accessible to all staff at ward level in a policy folder. It would have been referenced in training events such as MAPA. The charge nurse would make the ultimate decision on whether or not seclusion was to be used. Permission would be sought from the 12:41
medical staff with a specific reason for the need for the use of seclusion. The patient would have been monitored when in seclusion, with staff writing down their observations in a seclusion recording sheet. There was a specific time for recording, every five 12:41
minutes for the first 15 minutes, and then at 15-minute intervals. Regular reviews were completed by nursing staff on seclusion incidents, but I cannot recall the specific incidents. Medical staff also reviewed the patient whilst in seclusion, but I cannot recall 12:41
specific examples. The patient's notes would record details of the incident and also would have been recorded as an incident on Datix.

The monitoring of PRN medications, restraint, and 12:41
seclusion, were always recorded on Datix and would have been discussed at weekly MDT meetings. We would have discussed how often medication was administered, how many times restraint or seclusion was used, why it was used, and any patterns that we had noticed in a 12:42
patient's presentation. Seclusion was reviewed on a quarterly basis at senior nurse meetings. At ward level, every incident recorded on Datix was checked against the patient's daily notes by the ward manager

to ensure the details were correct and accurate. The incidents were to be reviewed within seven days by the ward manager, or the deputies if delegated, and any actions required would have been taken. For example, if there was a noted increase in the amount of times a patient needed to be restrained, it would have been brought to the MDT for discussion. This would have then prompted the need for a review of the patient's care plan or positive behaviour plan." 12:42

12:42

The witness then provides some detail and comments that she found her nursing role always clear and that she had support from her senior managers - sorry, from her charge nurse.

12:42

I want to move on to paragraph 41:

"If there were concerns raised about medication when I was on shift, I would have raised it immediately with the duty doctor. The protocol in place was to contact the duty doctor, then the senior registrar, who would have discussed any issues with the on-call consultant. There was a duty rota for medical staff which was sent to all wards. All staff were aware of this procedure. Any issues with medication could then have been recorded in the patient's notes. The consultants would never mind if you picked up the phone to them with a query and were always very helpful. The procedure regarding concerns would have been to record in the 12:43 12:43

patient's notes clinical observations being carried out to see if there were any signs of deterioration. This was standard nursing practice supported by the Policy and Medicines Code in the Belfast Trust. I have no experience with a patient deteriorating due to medication administration errors and never had to accompany any patients to the Accident & Emergency Department due to this. 12:43

If a patient from MAH had to attend the Accident & Emergency Department for a physical illness which staff at MAH could not deal with, or attend at a routine hospital appointment, there was always an MAH staff member with them. MAH had a good relationship with the A&E Department at Antrim Area Hospital. Nursing staff from MAH could phone ahead of the patient's transfer to inform the relevant department of the patient's needs. Antrim Area Hospital would have accommodated them by keeping an individual room free for them to wait, particularly if they had sensory issues, or by arranging a suitable time to come so that the patient could be assessed immediately." 12:43 12:44 12:44

The witness then goes on to give details of a different approach depending on the different types of patients, reflecting back on the wards that she has described earlier. 12:44

Picking up at paragraph 44:

"Staff would not always have been immediately made aware of a patient's profile at the initial admission stage, particularly if it was an urgent admission, only receiving the immediate presenting condition. However, this information would become clear shortly thereafter from the patient's community records, information gathered from the hospital staff, post-admission meetings and through weekly MDT meetings. There were separate meetings for families outside of the professional meetings. During my time on Six Mile I found that families did not have too much involvement with patients as they did on other wards. Often times a family member may have difficulty accepting the patient's offence and relationships had broken down. Within 48 hours of admission to MAH, patients on Six Mile would have had a risk screening carried out by a nurse, which was then brought to the MDT meeting. I would have been involved in collating the patient's information gathered from people who knew the patient best and from nursing staff's direct observations on the ward. This information would be reported back to the MDT, including identifying any risks the patient posed either to themselves or others. During MDT meetings, staff would have been made aware of the patient's particular skill set, if not already known or evident at the admission stage. All discussions and actions from MDT meetings would have been recorded in the patient's notes.

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Staff were notified, where possible, of the risks each patient might potentially pose. Discussions took place during handovers between night staff and day staff, who would inform other staff members of a patient's risks or any other issues happening on shift. Information shared at the staff handovers would have been based on what was recorded in the patient's notes. PARIS came into MAH in approximately 2014/2015, and would have been a positive initiative, as all professionals had access to the patient's notes. Previous to this it would have been recorded as a written entry in the patient's care plan. 12:46 12:46

After the 2017 CCTV investigation, safety briefings became more of a regular occurrence in MAH. They occurred on a daily basis. The senior nursing managers, H77 and H290, would have had daily calls with whoever was the nurse in charge of the ward that day to discuss any concerns with particular admissions and ways in which to make the wards safer for patients and staff." 12:46 12:47

The witness then outlines some details of Positive Behaviour Support, PBS, which was brought in, and other types of therapy that were introduced at that time. 12:47

The witness, at paragraph 48, sets out some detail of the day care arrangements that were available, and of

the speech and language therapy input that was provided, and that's in paragraph 49.

I want to pick up at paragraph 50:

12:47

"While there was Allied Health Professionals (AHP) services available to the patients within MAH, it would have been beneficial if there were more and if they were integrated more on the wards. However, there seemed to be resource issues for all the AHPs in their areas too. I cannot recall specifically, but I think in 2015 there were only two occupational therapists responsible for all of the wards in the hospital.

12:47

During my time in MAH as a Deputy Ward Sister I oversaw the care of patients through day-to-day observations. I would have also been given information at handovers with other staff between shifts who would have told me of any incidents that had occurred during their care for the patients. I would have taken the keys to the medications and carried out my rounds at the start of my shift to check on patients and ensuring every staff member was doing what they should be doing."

12:48

12:48

The witness then goes on to outline some of the supervision they would have taken with the patient care plans and incident reports. The witness also details holding patient forums within the wards, and sets out at paragraph 53 the review processes and audit of care

12:48

plans that would have happened on a monthly basis.

I want to pick up at paragraph 54:

"I felt there was experienced staff on hand to provide and deliver patients' care plans, however, this changed from 2016 when a lot of staff left the hospital. The effect of this on the patients was that they experienced increased anxiety as there were fewer experienced staff who understood their needs, which resulted in an increase in incidents and aggression. 12:48 12:49

MAH experienced staffing issues across all wards. This became more apparent from 2008 onwards. There were a lot of staff departures due to retirements, with key people leaving at that time, alongside changes in practices and staff having more options to work outside of the hospital as community services were developing throughout the province. When the new hospital wards opened, I think this created a divide within the hospital and a demoralization of the workforce. Certain staff, I recall, were apprehensive about their future at MAH, as there was a belief that staff working in the core hospital had job security whilst staff working in the resettlement units did not." 12:49 12:49

CHAIRPERSON: Sorry, can we just pause for a second?
MS. TANG: Yes.
CHAIRPERSON: I just want to check the dates. In 54

she's referring to 2016, and then in 55 she's referring to 2008. Now that may be correct. We may just need to change that, I mean to check that, because then in 56 she goes on to 2012, so it's a bit difficult to follow. Anyway, sorry for interrupting, but we may want to go back and check.

MS. TANG: Thank you, Chair, I'll note that.

CHAIRPERSON: Yeah.

MS. TANG: I'll pick up at paragraph 56: 12:50

"There was also a noticeable decline in morale amongst staff from 2012 onwards, which made matters progressively worse. I think this was because of the continued lack of clarity on job security in MAH, difficulty recruiting and retaining staff, closure of wards without consultation with medical staff or consideration of the impact on patients in which staff in the wards were left to manage these situations. There was also a very evident divide in 2012 between the new management at MAH and staff on the ground. MAH became a more difficult place to work in. The patients were difficult to manage with staff shortages and at this stage staff could no longer request a move to a long-stay or elderly ward. I remember myself and a Ward Sister, H214, raising staffing concerns with the Belfast Trust Central Nursing Team and the Director of Nursing, Brenda Creaney, in or around 2016, following a mass exodus of staff. Many trained nurses chose to leave MAH. One of the main reasons for this was the

uncertainty of the future of the hospital. Along with the pressures of working with patients with complex behavioural needs and high levels of aggression, I believe a culture of fear was developing amongst staff in MAH. Many experienced skilled learning disability nurses left in 2012. The impact of this led to more stressful working environments, increased staff burnout among existing staff, less safe environments for patients, with instability in environments that needed a constant and structured approach. 12:51 12:52

For many years there was a clear remit in relation to resettlement with patients who were admitted prior to 1996 being reported as PTL, priority discharge list patients, and patients who were treatment complete being placed on a delayed discharge list, whilst other patients were reported as still in active treatment. This remained in place throughout my time in MAH. 12:52

There were meetings between the senior nurse managers and Service Manager, H507, and Mairead Mitchell, Co-Director For Learning Disability, in relation to the downsizing of the hospital. I cannot recall how often these meetings would have occurred, but all staff on site could have attended. I recall some of these meetings being fraught with anxiety and many questions asked by staff in relation to the future of the hospital being left unanswered. The future of MAH was unclear for both patients and staff." 12:52 12:52

In paragraph 58 the witness outlines the management structure at that time, and I want to pick up at paragraph 59:

12:53

"I would have always felt comfortable approaching my direct line manager, which would have been the Ward Sister, Band 7, on the ward that I worked in at the time, with any concerns that I had or if I needed support with any issue from work. From around 2012 I 12:53
do recall that a lot of staff would have been wary about speaking out on any issues in relation to staffing issues, changes in the hospital, work pressures, due to the attitude of some of the senior managers in the hospital at that time. The nursing and 12:53
MDTs on the wards had difficulties with senior management at this time in terms of resettlement and the closure of wards. Any patients who were at MAH since 1996 were given priority for resettlement, which we understood to be directive from the Department of 12:54
Health. The resettlement of patients would have sometimes led to issues between senior management of the hospital and the MDT. There was a disconnect between the clinical team and senior management due to the speed of discharges and getting the right placement 12:54
to meet some of these patient needs appropriately. It was sometimes felt that the views of clinical teams were not being listened to and that the merging of patients from wards identified for closure would impact

on the patients themselves and on the patients in the core hospital wards. There seemed to be an emphasis on target driven outcomes for resettlement, causing instability in the hospital. H507, Services Manager, appeared more concerned with targets and getting patients resettled into the community than with the actual caring for the patients who were in the hospital.

During my time at MAH I recall some complaints being raised by patient's family members regarding the treatment or care of their relative, their continued detention in hospital, and difficulties securing placement for them in the community. This would have caused understandable frustrations. I recall over the years family members raising concern about the lack of activities for their loved ones. Staff would have tried to improve this, but at times it would have been hampered by the staff shortages and the downsizing of the hospital causing a lack of on site resources. There had previously been an on site entertainments officer, but this role was not filled when the individual retired from post. However, I did develop working relationships with patients' families, who would have given their view on a patient's care and would have suggested ways in which we could make life better for the patient. Patient's relatives would have complained about items of clothing being damaged. We would have tried to resolve by ensuring certain items

were washed on the ward at a certain time or taken home by relatives to look after, if they preferred to do so.

I recall one time a patient complaining to me that she was not happy with a certain staff member's attitude to her. She asked if I could speak to this staff member as she did not want to make a formal complaint. I cannot remember the name of the staff member and I can only remember the first name of the patient was P184. The patient did not wish for this to go through the adult safeguarding process and did have the capacity to understand the safeguarding process. I recorded her complaint in the patient's notes and was later advised by the ward social worker to complete an adult safeguarding referral." 12:56

The witness then describes completing some complaints forms on behalf of patients and typically that these related to meal choices.

The witness provides some detail at paragraph 63 on RQIA and the process of unannounced inspections.

And at paragraph 64, details some opportunities for CPD, Continued Professional Development. And at 65, clinical supervision and the ward cultures.

I want to pick up at paragraph 66:

"The presence of senior management on the wards varied, but I would say that they visited about two to three times a week up until 2012. After this time the visits decreased and became less frequent. When they did happen, the senior management or Trust Board would not have known staff members' names or indeed may not have been recognised by some staff members. There was never too much conversations during these visits as they would be in and out of the wards quite quickly. 12:57

Prior to 2017, senior managers relayed the introduction of CCTV in MAH at the Senior Nurse Managers meetings. A draft CCTV policy was sent to all ward managers for comment. I understand that CCTV was to be used as a tool to assist with investigating adult safeguarding incidents. I did not have any concerns about the initial introduction of CCTV in MAH. 12:57

In 2017, the incidents captured on CCTV showing abuse and ill-treatment of patients was reported in the news. At the time I was working in the Ardmore Ward. I was shocked and could not believe it. I felt a lot of trust was lost in MAH, based on the way it was being portrayed on social media and in the local news. It felt like all staff at MAH were guilty to the public, and patients' families, and of the same allegations by association. However, a lot of families did have great sympathy for the staff at MAH, who they knew were caring for their relatives as best they could at this 12:58 12:58

time. I recall a family member of a patient had informed me that he had contacted the Stephen Nolan Show, and the Newsletter, and was informed that they were not reporting good news stories on MAH so they did not wish to interview him. He wanted to inform the media of the good care his daughter received at MAH and of her supportive discharge from the hospital. 12:58

Following the allegations from PICU, social workers were assigned to come on to the wards in MAH to monitor the care on the wards on a daily basis for about a six month period. Unfortunately I felt it was not done in a co-working or respectful way. I felt the increased use of reviewing CCTV after each incident made it difficult for nursing staff to do their jobs with confidence and it felt like they were no longer trusted to do their jobs. The nursing staff carried on to the best of their abilities, but we were acutely aware of the public perception of MAH and staff was not good. I had concerns about the constant monitoring of patients, particularly patients with reduced capacity. If I had a family member in MAH I would not want them to be watched by strangers 24/7, seeing them at times in vulnerable states, distress, or agitation. I felt there was a lack of dignity with the process. However, I understood that this is what the Belfast Trust felt they needed to do to provide assurances to the families and to the Department of Health in relation to how patient safety was being monitored in MAH following the 12:59 12:59 12:59

abuse discovered on CCTV in 2017 and subsequent allegations.

From 2017 there was a significant deterioration in the hospital, with an increase in staff suspensions, along with culture of fear developing. The suspension process was very difficult as staff would have come on duty for their shift and then be suspended at various points throughout the day. At times some staff members were put on supervision plans in relation to adult safeguarding issues. However, these supervision plans were just broad themes which covered areas such as reporting, recording, meal time experience, mandatory training, communication. Staff would not often be given a specific reason as to why they needed a supervision plan concerning their practice, so this would have caused them some anxiety. This led to great uncertainty and a chaotic working environment. From 2018 there was a significant increase in the number of agency nurses used within the hospital. This further exacerbated the volatile situations on the wards. 13:00 13:00 13:00 13:00

Whilst senior management in Belfast Trust described an overhauling of the service with highly skilled nurses travelling from the UK, in reality this was not the case. Most of the agency nurses had trained in mental health nursing and had little experience of caring for people with learning disabilities. This created difficult working environments. I would describe this 13:01

time in my career as very stressful.

Around 2019 there was a provision of psychological support for staff in MAH, facilitated by a psychotherapist. These sessions were made available to all staff of various grades and professions who worked in the hospital. I felt this was a very supportive mechanism, and while it was well attended by the professional staff in MAH, the service was ultimately withdrawn by the psychotherapist due to a lack of support by senior managers within the hospital at that time. The psychotherapist and staff in MAH felt that the senior management should have attended those sessions also. 13:01 13:01

Reporting requirements definitely changed following the 2017 HR and safeguarding investigations. We started to see governance meetings taking place with clinical directors, directors and co-directors. Many staff did find this intimidating given the seniority of the staff who would be on the calls and sometimes would not know who exactly was present on the calls. A lot of managers were new to the hospital, so staff would not have always been aware of their specific roles and remit. It was a very turbulent time, with much frequent change and turnover in the senior management structure in MAH and at Trust level. The purpose of increased meetings was to have a governance overview of the incidents of violence and aggression and adult 13:02 13:02

safeguarding incidents which occurred in the previous week. There were also weekly patient meetings to discuss any events that took place in the week before and to discuss what protection plans, if any, had to be put in place. I would have contributed to these calls and meetings if I was on duty on the day the meetings were occurring. 13:02

The abuse scandal in MAH has had a profound effect on many people, on the service as a whole, and for people with learning disability. Over the years MAH provided a place for people with mental health and learning disabilities when no other support was available in their family homes or in their communities. 13:03
Significant changes came about for people with learning disabilities with improvements in health care and changes to social care and national policies, in that hospital was viewed as a place for assessment and treatment and not as a place to live. But this was a slow process in MAH due to the complex needs of some of the patients and the lack of suitable resources and facilities in the community and in wider society to support them. I felt that it has taken a very long time for service improvements in the learning disability field to come about, not only due to funding issues, but a lack of vision for service development in Northern Ireland. I feel that people with learning disabilities do need specialised in-patient assessment and treatment facilities with multiprofessional support 13:03 13:03

during times of crisis in their lives . I hope this Inquiry will go some way in making recommendations which improve services for people with learning disabilities and mental health in Northern Ireland."

13:04

CHAIRPERSON: Right. Well thank you very much indeed. And, again, thank you to the witness for that statement and the effort that has gone into it.

I think that completes our evidence for today. 13:04

On Monday we are starting OM7. There will be, I understand, a brief introduction to the evidence of OM7, and then we'll move into that part -- I'm sorry I don't invite oral submissions. 13:04

MS. ANYADIKE-DANES: I wasn't going to make an oral submission, it was just a question, but you wouldn't be able to hear me.

CHAIRMAN: Sorry. All right. Okay.

MS. ANYADIKE-DANES: In the light of that statement 13:04 which has been read, and I understand that the Panel has seen, or rather you have, Chair, have seen reasons why the witness shouldn't be called to give evidence. Would it nonetheless be possible to provide questions that you might consider putting to that witness so they 13:05 could be answered in writing?

CHAIRPERSON: I think the best I can do is you can write your questions and I will then have to consider whether it's appropriate.

MS. ANYADIKE-DANES: Thank you very much. I'm very grateful.

CHAIRPERSON: There are real sensitivities around this.

MS. ANYADIKE-DANES: Of course.

CHAIRPERSON: I'm afraid you have to trust me on that. 13:05

MS. ANYADIKE-DANES: I do, and that's why I'm putting it in that way. If we submit them to you and if you consider that they're helpful and that the witness will be in a position to address them, then maybe you'd find a way. 13:05

CHAIRPERSON: Okay. All right. Thank you.

Sorry, I was just saying, so we're starting OM7 on Monday. There are a few staff witnesses left, I think about three or four, who couldn't be slotted into the 13:05 present sessions, but those will be coming in a week or so, and we hope to finish all of the staff evidence certainly by the end of this month.

All right. Well, can I wish everybody a good weekend 13:06 and we'll see you back at 10:00 o'clock on Monday. Thank you very much.

THE INQUIRY ADJOURNED UNTIL MONDAY, 16TH SEPTEMBER 2024 AT 10.00 A.M. 13:06