

MUCKAMORE ABBEY HOSPITAL INQUIRY
SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL
ON MONDAY, 3RD JUNE 2024 - DAY 86

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

86

GWEN MALONE STENOGRAPHY
SERVICES

APPEARANCES

CHAIRPERSON :	MR. TOM KARK KC
INQUIRY PANEL :	MR. TOM KARK KC - CHAIRPERSON PROF. GLYNIS MURPHY DR. ELAINE MAXWELL
COUNSEL TO THE INQUIRY :	MR. SEAN DORAN KC MS. DENISE KILEY KC MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MS. RACHEL BERGIN BL
INSTRUCTED BY :	MS. LORRAINE KEOWN SOLICITOR TO THE INQUIRY
SECRETARY TO THE INQUIRY :	MS. JACLYN RICHARDSON
ASSISTED BY :	MR. STEVEN MONTGOMERY
FOR ACTION FOR MUCKAMORE & SOCIETY OF PARENTS AND FRIENDS OF MUCKAMORE :	MS. MONYE ANYADIKE-DANES KC MR. AIDAN MCGOWAN BL MS. AMY KINNEY BL
INSTRUCTED BY :	PHOENIX LAW SOLICITORS
FOR GROUP 3 :	MR. CONOR MAGUIRE KC MS. VICTORIA ROSS BL
INSTRUCTED BY :	MR. TOM ANDERSON O'REILLY STEWART SOLICITORS
FOR BELFAST HEALTH & SOCIAL CARE TRUST :	MR. JOSEPH AIKEN KC MS. ANNA MCLARNON BL MS. LAURA KING BL MS. SARAH SHARMAN BL MS. SARAH MINFORD BL MS. BETH MCMULLAN BL
INSTRUCTED BY :	DIRECTORATE OF LEGAL SERVICES

FOR DEPARTMENT OF HEALTH: MR. ANDREW MCGUINNESS BL
MS. EMMA TREMLETT BL

INSTRUCTED BY: MS. CLAIRE DEMELAS
MS. TUTU OGLE
DEPARTMENTAL SOLICITORS
OFFICE

FOR RQIA: MR. MICHAEL NEESON BL
MR. DANIEL LYTTLE BL

INSTRUCTED BY: DWF LAW LLP

FOR PSNI: MR. MARK ROBINSON KC
MS. EILIS LUNNY BL

INSTRUCTED BY: DCI JILL DUFFIE

COPYRIGHT: Transcripts are the work of Gwen Malone
Stenography Services and they must not be photocopied or
reproduced in any manner or supplied or loaned by an
appellant to a respondent or to any other party without
written permission of Gwen Malone Stenography Service

INDEX

WITNESS	PAGE
<u>H324</u>	
EXAMINED BY MR. MCEVOY	5
STATEMENTS OF OLIVER SHANKS -	
REFERENCE STM-031 AND STM-244.....	113
STATEMENT OF H303 - REFERENCE STM-211.....	133

1 THE INQUIRY RESUMED ON MONDAY, 3RD JUNE 2024 AS
2 FOLLOWS:

3
4 CHAIRPERSON: Yes, is there any application in relation
5 to this?

09:56

6 MR. McEVOY: There is no need for an application,
7 Chair. I think there was an application, but the basis
8 for it has been resolved, so I think we can proceed.

9 CHAIRPERSON: And we can deal with the paragraphs in a
10 suitable way?

09:56

11 MR. McEVOY: In a suitable way.

12 CHAIRPERSON: which the -- I think it was the PSNI have
13 some concerns. All right. Can we get the witness in?
14 Thank you.

09:57

15
16 H324, HAVING BEEN SWORN, WAS EXAMINED BY MR. McEVOY AS
17 FOLLOWS:

18
19 CHAIRPERSON: Good morning.

20 A. Morning.

09:57

21 CHAIRPERSON: We've met briefly outside. Can I just
22 thank you very much for coming to assist the Inquiry.
23 If you want a break at any stage you know just to let
24 me know, and I'll hand you over to Mr. McEvoy.

25 A. Okay. Thank you.

09:58

26 MR. McEVOY: Okay. Well, good morning.

27 A. Morning.

28 1 Q. And for today's purposes you're known as H324. So good
29 morning H324. Before you is a little folder with your

1 Inquiry statement dated 22nd May 2024.

2 A. Mhm-mhm.

3 2 Q. And I have some questions arising for you from that
4 statement?

5 A. Okay. 09:58

6 3 Q. In the statement you tell us that you worked as a Band
7 5 Staff Nurse at Muckamore and you started there indeed
8 at Muckamore in February 2008 as a student nurse?

9 A. Yeah.

10 4 Q. And your time as a Band 5 then began in January '13 09:58
11 until August '15, and then at Section 3 you tell us
12 that you're a Band 7 nurse currently within the Belfast
13 Trust?

14 A. Yeah.

15 5 Q. Are you -- what area are you working in now? 09:58

16 A. I am working in the community.

17 6 Q. Okay.

18 CHAIRPERSON: Mr. McEvoy, just for process, do you want
19 to ask her to confirm that her statement...

20 MR. McEVOY: Yes, you're content. 09:59

21 A. Yeah. Yeah.

22 MR. McEVOY: Content to adopt your statement.

23 CHAIRPERSON: Thank you.

24 MR. McEVOY: And you are in the community, and in band
25 -- I beg your pardon, in paragraph 3 you tell us that 09:59
26 you qualified from Queen's in 2011 as a registered
27 learning disability nurse.

28 A. Yeah. Yeah.

29 7 Q. And are you still working within learning disability

1 now?

2 A. Yes, I am, yeah. In Community Learning Disability
3 Services.

4 8 Q. Okay. In terms of what you tell us at paragraph 4
5 then, when you went on to take up a post as a Staff 09:59
6 Nurse in Muckamore in January '13, you tell us that you
7 were supposed to be starting in Donegore, but then you
8 were asked by H77 to go and work on Greenan?

9 A. Yeah.

10 9 Q. Which you describe as a nursing care ward with around 09:59
11 28 patients, with the majority being wheelchair users,
12 and "I spent some time on this ward as a student", you
13 were happy to accept and stated you'd be happy to work
14 there. And you say you loved the ward?

15 A. Mhm-mhm. 10:00

16 10 Q. And the Sister in charge in Greenan when you were a
17 student nurse was H154, and she was still there then
18 when you went back in 2013. When you took up the role
19 in January 2013, you say it was a temporary post on a
20 rolling contract for about three months in duration? 10:00

21 A. Yeah.

22 11 Q. And you tell us then the hospital was supposed to be
23 closing?

24 A. Mhm-mhm.

25 12 Q. Can you tell us how did you know that at this point in 10:00
26 time?

27 A. Well I suppose it was in keeping with the government
28 guidelines that the long stay hospitals for people with
29 learning disabilities were going to be closing and a

1 lot of them had been identified for resettling. It was
2 just a matter of getting resettlement placements. So
3 that was -- for a long period they weren't employing
4 people as permanent Staff Nurses, and during that
5 period I think they were redeploying Band 3s into the 10:00
6 community because they had too many staff at that time.
7 13 Q. Okay.
8 CHAIRPERSON: You are a really fast talker.
9 A. Sorry. That's me trying not to talk fast! Sorry.
10 CHAIRPERSON: So between you and Mr. McEvoy, if I could 10:01
11 ask you just to take a breath occasionally. All right.
12 A. Yes. Sorry.
13 MR. McEVOY: All right. Take your time.
14 DR. MAXWELL: Can I just ask you about that? You said
15 that Band 3s were being re deployed to work in the 10:01
16 community.
17 A. Yeah, yeah, yeah.
18 DR. MAXWELL: So at that time would it have been your
19 perception that the hospital was over-staffed?
20 A. Well working on the ward I wouldn't have felt that it 10:01
21 was over staffed, but they had said -- I think what the
22 vision just had been, our understanding would have been
23 that they had wanted a higher percentage of Band 5s due
24 to the client group that was going to be likely in the
25 core hospital. So working on the ward I didn't think 10:01
26 it was over staffed, but they had felt that they were
27 over staffed in Band 3s -- so maybe about -- I don't
28 know a dozen, half a dozen people were sort of
29 redeployed to community settings, either in residential

1 homes, supported living, or some of the day care
2 places. And I know too a couple of them went then to
3 like a community behaviour team from Muckamore.

4 DR. MAXWELL: So I understand the vision, but of course
5 there's a lot can happen between a vision and reality. 10:02
6 So the vision was we're closing it, we'll move
7 everybody out, but your experience was that actually
8 there weren't enough staff for the patients who were
9 left. Is that correct?

10 A. Yeah. Yeah. I think -- from memory I think people had 10:02
11 been given an option, because of the vision, had been
12 given an option to apply for redeployment because they
13 had wanted the core hospital of like the admissions
14 ward or the longer stay, or the forensic ward, they had
15 wanted those to be mostly staffed by Band 5 Staff 10:02
16 Nurses due to the clients that were going to be in it.
17 So I think that might have been what their idea was,
18 but the reality was we were very short staffed.

19 DR. MAXWELL: You also say, I think, that they weren't
20 offering substantive posts to Band 5. 10:03

21 A. No. No.

22 DR. MAXWELL: So if the vision was 'we'll have less
23 threes and more fives', but they weren't actually
24 recruiting substantive Band 5s, that seems a little
25 odd. 10:03

26 A. Well it was very odd, and we used to wait to get our
27 contracts. It would have been maybe like the week
28 before the contract was running out that would have
29 been the first time you got any sort of correspondence

1 that you were going to be given another three months.
2 So it was kind of...

3 DR. MAXWELL: Can I ask, as somebody just qualifying
4 and you're thinking you've got your whole career ahead
5 of you, would going to somewhere on a temporary
6 contract that you thought was imminently closing be
7 seen as a good career move?

10:03

8 A. Well I had initially, when I first qualified, had
9 worked down in Newry, and so that was about an hour,
10 well about 45 to an hour's away, depending on the
11 traffic and how I was driving, to get there. And then
12 I took a post in Coleraine, which was an hour the other
13 way from my house. So when the opportunity just came
14 up to work in Muckamore, it was 15 minutes away from my
15 house, and I probably wasn't thinking long-term career,
16 I was just thinking short-term that it was more
17 convenient rather than spending an hour driving too and
18 from work working in the nursing home. Going to Newry
19 we'd have been doing like five nights in a row because
20 of the way the duty fell, the week starting and the
21 week ending, which was very tough. I did it for 13
22 months and then got worked up in Coleraine, and my
23 brother-in-law was a mechanic and told me off for the
24 abuse to the car, and I was tired, so I needed to work
25 somewhere closer to home just.

10:03

10:04

10:04

10:04

26 DR. MAXWELL: So your choice to go to Muckamore wasn't
27 a career choice, it was a pragmatic choice?

28 A. Well I suppose it was a career choice as well. I was
29 working for the agency in the community in Coleraine,

1 so I suppose it was a wee bit more stability and it was
2 just something at that time that I felt was the right
3 thing to me do for me.

4 DR. MAXWELL: I will stop in a minute, but you were
5 working for the agency, is that because they weren't
6 recruiting community RNLDs either? 10:05

7 A. That was due to -- they were really short staffed and
8 they needed somebody in quickly and I got it through
9 the agency.

10 DR. MAXWELL: But were community RNLD posts available? 10:05

11 A. This was a Band 5 one, so I'm not sure whether or not
12 in the Belfast Trust they were available at the time.
13 I just had seen that this was a Band 5 in the Northern
14 Trust was available and I applied for it just.

15 DR. MAXWELL: Thank you. 10:05

16 A. I just took the opportunity.

17 DR. MAXWELL: Thank you.

18 14 Q. MR. McEVOY: You were able to apply for a permanent
19 post then in 2014.

20 A. Mhm-mhm. 10:05

21 15 Q. And you had to re-apply and then interview for it?

22 A. Yeah.

23 16 Q. And then that post, your understanding was that it was
24 going to be in Cranfield Men?

25 A. Mhm-mhm. 10:06

26 17 Q. But in fact then in around October or November of that
27 year you were told then that you were being moved to
28 Moylena as Greenan was due to close?

29 A. Mhm-mhm.

1 18 Q. And you can't recall who informed you of that move.
2 You expressed your view and your understanding that you
3 were supposed to be commencing your permanent post in
4 Cranfield and your line managers told you that they
5 didn't want to lose you, your experience working in 10:06
6 resettlement, and you were moved then to Moylena. You
7 say:
8
9 "If Greenan was still open today I would probably still
10 be there, as I really loved it. The only reason I left 10:06
11 Muckamore at all..."
12
13 - would that be fair to say?
14
15 "...was because of an opportunity to get a Band 6 post 10:06
16 in the community."
17 A. Yeah.
18 19 Q. Then you tell us you didn't have any family or friends
19 working in Muckamore when you started. You then
20 describe your induction as a Band 5. You're very 10:07
21 familiar with the hospital. You remember H154 going
22 through the policies with you and the mandatory
23 training that you did?
24 A. Mhm-mhm.
25 20 Q. Again you emphasise how much you enjoyed working on 10:07
26 Greenan, describing it as a nursing care ward for long
27 stay patients, many of whom had been in the hospital
28 for many years and were mostly older. Most patients
29 were profoundly disabled with a history of psychotic

1 disorders, a tough job physically, which you enjoyed.
2 Patients were wheelchair users and required the use of
3 a hoist for transfers. Although you recall a key pad
4 on the door, it was an open ward, and the key pad you
5 think was installed, or you recollect was installed, as 10:07
6 a patient from another ward had entered the ward and
7 had attacked a profoundly disabled patient, leaving
8 that person with scars. But staff and families had the
9 code and came in and out as they pleased?

10 A. Yeah. 10:08

11 21 Q. Okay. You then go on and tell us about Ennis ward,
12 which you worked on as a student, describing it as a
13 locked ward, a women's ward, which you recall had a lot
14 of slapping and grabbing in this ward from the
15 patients. The women on that ward being moved to the 10:08
16 community. And there were a lot of In-Reach staff from
17 the community coming to the ward to meet with the
18 patients. Cranfield women's ward was another ward you
19 were placed in as a student, it was an admissions ward,
20 and you describe that as being an eye opener. 10:08

21 A. Mhm-mhm.

22 22 Q. When you there the ward wasn't long open. The hospital
23 was trying to move from an old institutionalised style
24 operation, you say, and the ward was all one open
25 space. Cranfield Men's and Cranfield women's wards 10:08
26 were beside each other and both wards were open, which
27 meant that the men and women patients could see each
28 other. It could be, you say, a hectic environment to
29 be in, and potential mixing of the patients caused a

1 lot of tension. If there was ever an incident when
2 staff were occupied, patients would take advantage of
3 the staff being distracted. And then you describe some
4 of the techniques for breakaway when you were at
5 Queen's on placement.

10:09

6
7 You weren't MAPA trained as a student, but you now know
8 that for the Cranfield wards breakaway techniques were
9 not sufficient, and you remember that being raised with
10 Queen's and being told that you shouldn't be present if 10:09
11 an incident was occurring. This would have been
12 difficult as a student as staff would have been trying
13 to manage or diffuse a situation, maintain patient
14 safety, staff, and also students. But you certainly
15 learned de-escalation skills from your experience 10:09
16 there. During your time in Cranfield women's you
17 recall there were a lot of incidents, but none which
18 you can recall specifically. You then describe going
19 to F3 after Cranfield Women's, that being a male long
20 stay ward. A lovely ward to work on, you say, which 10:10
21 had a big dormitory where the patients slept.

22
23 "The ward had been sectioned off using furniture to
24 create smaller private areas."

10:10

25
26 This, you felt, was the best they could do with the
27 resources available at the time. The patients were
28 happy, but you do recall there were a lot of incidents
29 on the ward also. There was one incident you recall as

1 a student where a Staff Nurse had her two front teeth
2 knocked out by a patient. As a Staff Nurse working in
3 Muckamore you say that would you rather have worked on
4 the male wards than the female wards. Is there a
5 reason why you say that? Was it a personal preference 10:10
6 or was it --

7 A. Yeah, I suppose it was personal preference, but on the
8 female wards the female patients at times would have
9 been a lot nastier, and probably a lot more vicious.
10 And with the males, from experience with the male 10:10
11 patients, if there was an issue on the day it was dealt
12 with on the day, or like it was there and done and
13 dusted on the day, whereas the females would have like
14 recalled something like six weeks before that you might
15 not have even remembered or might not have been on 10:11
16 duty. So they were probably that wee bit nastier to
17 work with. And they would have been a bit more vicious
18 that they would have been scratching at you, like
19 scratching and grabbing at you more than what the male
20 patients would have. 10:11

21 23 Q. Okay. You then tell us that when you were asked to
22 move from Greenan to M4 as a Staff Nurse, you weren't
23 happy, because as you've mentioned you loved Greenan.
24 And when you arrived to work in M4 it was chaotic and
25 very short staffed. 10:11

26 A. Mhm-mhm.

27 24 Q. Management at the time were H355 and H426. One was a
28 Band 6 and the other Band 7. You can't remember which
29 way about. Before moving on, during the period of

1 2013/2014 when you were new in post, can you tell us
2 something about how the closure of wards and the
3 movement of patients affected them?
4 A. Affected the patients?
5 25 Q. Patients. Yeah. 10:12
6 A. Yeah, it was a having a negative impact on a lot of the
7 patients and their families, particularly in Greenan.
8 Like a lot of those ladies had been in the hospital for
9 the guts of 30/40 -- I think there was one was there
10 even for 50 years -- and the families were really 10:12
11 really upset. They understood, like we would have
12 explained to them that it wasn't us, do you know,
13 because like a lot of, like we would have had people
14 like -- I remember a particular family like they were
15 "why are you doing this?", and we were like -- it's not 10:12
16 we're doing it, but we're having to facilitate it
17 because it is in line with the government guidelines
18 that people shouldn't be in long stay hospitals. I
19 felt that it was impacting on patients because they
20 were being moved from -- sorry. They were being moved 10:12
21 from a place where they had been for a very long time,
22 familiar with other patients and familiar with staff.
23 That aside we were aware like what resettlement was and
24 there was no real need for people to be in the hospital
25 that length of time, but just given they had been there 10:13
26 for so long and familiar surroundings, it was tough.
27 Like it was really, really tough, and we would have
28 seen some of the patients physically deteriorating, do
29 you know. Like you were talking about people who

1 didn't have capacity, and they probably were wondering
2 'why am I being moved?', do you know.

3 CHAIRPERSON: Can I just ask you, let's assume that
4 those moves were absolutely necessary, just take that
5 -- 10:13

6 A. Necessary?

7 CHAIRPERSON: Necessary. Take that as a sort of
8 assumption.

9 A. Yeah.

10 CHAIRPERSON: How was the preparation for those moves 10:13
11 done? How long did you have?

12 A. We would have had weeks and weeks. It probably
13 depended on the placement or depended on their staff.
14 In Greenan, in particular, we would have had a lot of
15 In-Reach staff. So one particular place we had six 10:13
16 ladies were going to one nursing home and they nearly
17 became part of the ward staff, they were there that
18 often, and then when the ladies eventually did move the
19 six of them together we then staffed, we like -- like a
20 Staff Nurse and a Nursing Assistant would have went 10:14
21 down to the nursing home and sort of been present to
22 facilitate the resettlement, but sort of to allow the
23 staff to work on it, but we were there as the people
24 that knew the patients the best.

25 PROFESSOR MURPHY: So that was an example of 10:14
26 resettlement well handled, but did you see examples
27 where it didn't go that well?

28 A. Well, a personal opinion? I suppose I can think of one
29 or two that they were moved and they physically

1 deteriorated. Probably -- it might be just our
2 feelings, but we know like the people sort of -- well
3 there was one particular lady I can think of that when
4 she moved to the nursing home she had always had a
5 great appetite when she was on the ward, and when she 10:15
6 moved to the nursing home she didn't, her appetite
7 deteriorated, and just her physical appearance -- she
8 did lose weight and she just didn't seem herself. So
9 we had sort of talked to the, the nursing home
10 contacted us then like 'You told us she has a great 10:15
11 appetite, do you know, this is not what's being shown
12 here'. So some of the staff were sort of deployed down
13 to the nursing home at different times to sort of
14 familiarise the staff or familiarise her with the area
15 so that we sort of -- and a different -- I remember I 10:15
16 was one of the people going down to sort of feed her
17 and sort of participate in her care to try and make it
18 more pleasant experience for her. She would have been
19 profoundly disabled and non-verbal, but quite clearly
20 that the move did have an impact on her life. 10:15

21 PROFESSOR MURPHY: Thank you.

22 26 Q. MR. McEVOY: Okay. Then you tell us then at paragraph
23 13 at the top of page 5, before you were moved as a
24 Staff Nurse from Greenan to M4 you had been off for
25 personal reasons for six to eight weeks, and then you 10:16
26 went back for a week before going over to M4. While on
27 M4 then, sorry, you describe a patient who had tried to
28 sexually assault the staff on many occasions. You
29 recall an incident in December '14 where that patient

1 punched you in the lower abdomen womb area, causing you
2 injury, and you were off for a number of weeks
3 afterwards. During that time when you were off, H377
4 contacted you and asked if you would come back to
5 Cranfield Men's Ward, as you were originally supposed 10:16
6 to, that was your original understanding, because the
7 Christmas off duty was short. When you came back in
8 January '15, Greenan was closed and you were still on
9 M4.

10 A. Mhm-mhm. 10:16

11 27 Q. Greenan had closed and H154, who you seemed to have got
12 on well with, would that be fair to say?

13 A. Yes.

14 28 Q. Was then moved to M4 and was the Sister in charge.
15 During your time in M4 you staffed for a period the 10:17
16 Oldstone Bungalows, which was a resettlement section
17 across the road from the main Muckamore site.

18
19 "I cannot recall how long we did this for."

20
21 You were the only Staff Nurse there for three patients.
22 Two of them had a forensic history and one was still
23 the subject of a hospital order, and you had no, you
24 say, no -- you had never worked with patients of that
25 kind and had no training to do so. How did you feel 10:17
26 about that?

27 A. It was just part of your job. I suppose before we went
28 over when we were staffing then the Oldstone, we were
29 given a run down, you know, like an introduction to the

1 patients, we had access to their nursing file. We were
2 aware of what the past of the patients were.

3 29 Q. Yes.

4 A. And I suppose sort of what -- you were given sort of
5 advice or sort of like -- I can't think of the word, 10:18
6 sorry. Like an introduction to the patient and sort of
7 explained sort of who and what, just absolutely
8 everything, and about the history. I didn't feel --
9 and just from reading that I suppose I didn't really
10 feel, you know, as a registered Staff Nurse, so long as 10:18
11 I had had the information on the patient I don't feel
12 that I would have necessarily needed specific training
13 for those particular patients. We weren't doing any --
14 they were identified as being resettled or discharged.
15 So I suppose there wasn't anything -- there was no 10:18
16 specific or proactive work being done with the forensic
17 side of things, so I wouldn't have needed to have
18 specialist.

19 30 Q. Yes. Yes.

20 A. Just reading that and just I don't think I would have 10:18
21 needed...

22 31 Q. That's fine.

23 A. I suppose it was just part of your job that you had to
24 do, and it was grand. We had a phone and you would
25 have rang over if you needed anybody. You would have 10:18
26 rang the ward. I'd have rang the Charge Nurse of the
27 Forensic ward. I don't see a cipher.

28 32 Q. Yes.

29 A. If you needed anything. Because sometimes other

1 patients from the other ward would have come over and I
2 would have rang over just to make sure that like they
3 were all right to mix, because I didn't know the full
4 history of absolutely every single patient that wasn't
5 on that ward, or the nursing office you would have rang 10:19
6 if you had needed support. But generally it was fine,
7 it was just part of your work.

8 33 Q. Okay. On M4 then, in paragraph 14, you tell us that
9 all the male patients were able-bodied or predominantly
10 able-bodied. Some of them required constant 10:19
11 supervision, different levels of supervision, recorded
12 as Level 2, which was supervision every 15 minutes.
13 Level 3 was within eye contact at all times, and then
14 Level 4, which was when a patient had to be within
15 arm's length at all times. The ward was short staffed 10:19
16 and you were left with one-to-one supervision of a
17 patient while taking charge of the ward. That's the
18 same patient that injured you?

19 A. Mhm-mhm.

20 34 Q. And you highlighted this to your line managers H823 and 10:20
21 H377. They kept saying they were aware and they would
22 do something about it, but nothing ever happened.
23 How did you feel about your personal safety during this
24 time? I mean you've described one injury in the
25 previous paragraph? 10:20

26 A. Yeah. I don't know. I don't know. I suppose at that
27 time I felt that my concerns were not being taken
28 seriously, and I suppose that I had expressed -- like
29 so I had expressed to the management that are mentioned

1 there my concerns, even when I first came over there,
2 before anything had happened, my concerns of taking a
3 Level 3 one-to-one and being in charge of the ward,
4 because there was other things you needed to be doing
5 if you were taking charge of the ward and you couldn't 10:20
6 give a Level 3 supervision.

7 35 Q. Yes.

8 A. So I had highlighted that before anything had actually
9 even happened. So personally my safety was compromised
10 and I felt sort of at risk, and then when I was injured 10:21
11 it sort of -- I was right to be feeling I was at risk.

12 36 Q. And you've described your moves around the various
13 wards and what was going on in the various wards during
14 this time. Were there particular wards that were more
15 short staffed than others? 10:21

16 A. I'm not sure. I suppose when you were in the ward you
17 were only concerned with your own ward, but from
18 experience with M4 in Greenan, if we were ringing over
19 to get -- we would have rang over to the nursing office
20 to get the nursing officer. 10:21

21 37 Q. Yeah.

22 A. And I would have always proposed if they could give me
23 staff 7:25 to 9:00 o'clock so we could get the people
24 up and get their breakfast and get their medicine and
25 then get them off to day care, that generally the 10:21
26 other, like the more able wards in the core, is what
27 they deemed the core, a lot of those patients sort of
28 lay on to after 10:00 maybe. So that was how I always
29 sort of proposed if we got staff. But I never --

1 38 Q. Sorry, I didn't catch the hours there. What was the
2 busy time?

3 A. 7:25 to 9:00.

4 39 Q. Yes.

5 A. So that would have been our really, really busy time. 10:22
6 So I would have rang -- like they used to laugh, I used
7 to ring and say 'Listen, if you give me somebody 7:25
8 to 9:00 o'clock that will make all the difference here.
9 We can get these ones up, washed, dressed, get them
10 their breakfast', and a lot of them were going to the 10:22
11 day care on site.

12 40 Q. Yes.

13 A. So if we could get that 7:25 to 9:00, particularly in
14 Greenan, like that made all the difference. I suppose
15 from my experience our ward was always short, and I 10:22
16 suppose on different occasions I was sent out on
17 relief, so I would imagine maybe that all the wards
18 were of a similar...

19 41 Q. When you say "sent out on relief", can you just explain
20 what that means? 10:22

21 A. Yeah. So again when I rang the nursing officer they
22 would take somebody else from another ward to staff
23 another ward, so that would be deemed relief. So we
24 would have had a relief book that everybody's name and
25 where they went, so there was a record of it so that it 10:22
26 was fair. So if my name hadn't been there in the last
27 10 goes, it would have been my go. You'd have had to
28 just do it methodically like that.

29 42 Q. Yes.

1 A. So you could have been sent to any...

2 43 Q. So you would have had to go somewhere else?

3 A. Yeah, yeah, yeah.

4 DR. MAXWELL: Can I ask about the shift patterns?

5 A. Yeah. 10:23

6 DR. MAXWELL: It's common in other areas of nursing to

7 have shifts that reflect the patient needs. So, to

8 have people who work after is because, as you say,

9 getting people up in the morning and breakfasting, that

10 takes quite a lot of person power. Dementia wards 10:23

11 often have this concept of sun downing, that people's

12 behaviour seems to deteriorate in the evenings so

13 they'll have twilight shifts.

14 A. Yeah.

15 DR. MAXWELL: Was there ever any consideration given to 10:23

16 having these different types of shifts on different

17 wards to meet different patient's needs?

18 A. There would have been twilight shifts across the

19 hospital.

20 DR. MAXWELL: There were twilight shifts? 10:23

21 A. There would have been a 6:00 to 11:00. So you would

22 have had a.m. was 7:25 to 1:00 o'clock, and the p.m.

23 was 12:45 to 8:30. But there would have been -- we

24 would have -- the 6:00 to 11:00 workers, and they would

25 have worked 6:00 to 11:00, and then, what was that, 10:24

26 then you could have done a long day or the night duty.

27 But there was -- we would have had twilights.

28 DR. MAXWELL: Okay. But you didn't have a morning

29 shift?

1 A. No, just the 7:25 to 1:00. There was never...
2 DR. MAXWELL: And when you say that the ward was short
3 staffed, was it short for the whole shift or just round
4 these particularly intense periods? So after 11:00 or
5 12:00 until about 6:00, was the ward adequately 10:24
6 staffed?
7 A. On days, yes, it would have been, because there would
8 have been maybe more people -- like we would have had
9 people that didn't work mornings, or people that didn't
10 work after 6:00am, it just really depended. It 10:24
11 depended on staff leave, staff sickness, you know. It
12 wasn't like chronically short every single day on every
13 single shift. We could have obviously done with more
14 staff on each shift on each day. But, yeah. I suppose
15 we got it done, do you know, is the thing, and I 10:25
16 suppose from that point of view it was adequately
17 staffed, but it would have really depended. It wasn't
18 any particular -- you know, it wouldn't have been like
19 'Oh, my goodness, we're always short in the morning
20 times', you know, it was... 10:25
21 DR. MAXWELL: But if you're very taken up with trying
22 to get everybody's personal hygiene done, get them
23 dressed, have breakfast, how much time does that leave
24 for the positive behaviour programmes, for the
25 activities for things? 10:25
26 A. Not a lot.
27 DR. MAXWELL: So there was work left undone, to use the
28 current phrase?
29 A. Yeah. Yeah. We would have done -- we would have been

1 trying to allocate staff on the allocation sheet to try
2 to make sure -- because that would have been something
3 that would have been brought up by the RQIA, that like
4 ward based activities or things weren't being carried
5 out, so there was a big drive at a time on the 10:25
6 allocation sheets, like I would have -- myself or
7 anybody would have been personally allocated to ensure
8 that activities were carried out. So like after 9:00
9 o'clock, or after everybody has had their -- got up
10 washed and dressed and out to day care, and after sort 10:26
11 of like the staff breaks in the morning, there would
12 have been, somebody would have been allocated to that,
13 no matter what happened they would have had to do that.
14 But it might have meant that as nurse in charge you
15 were maybe going putting laundry away to allow some 10:26
16 other member of staff to do those tasks.

17 DR. MAXWELL: It doesn't seem like a good use of
18 resources?

19 A. We did what we had to do, do you know. It was just
20 kind of -- yeah. 10:26

21 DR. MAXWELL: So as far as you know, when people were
22 determining how many staff you need, were they just
23 looking at people's physical needs or were they looking
24 at all these other things that you do as part of
25 providing care? 10:26

26 A. I would imagine that it was their physical needs.
27 There was never any formal discussion that I would have
28 been involved in with that, but knowing what we got and
29 what we had, I would imagine there's the physical

1 needs, meet their physical needs first.

2 DR. MAXWELL: Okay. Thank you.

3 44 Q. MR. McEVOY: Now at paragraph 15 in the bottom of page
4 5, you say that in line 4 that you would describe the
5 culture on M4 as "okay": 10:27

6

7 "People just got on with what they had to do. Like any
8 ward, some people were happy, some were not, and some
9 just liked to moan. There were a lot of older men
10 working on M4. It was a high incident ward. Patients 10:27
11 would attack staff quite a lot of the time, often
12 involving biting and punching. The male staff on the
13 ward would have ensured the safety of patients on
14 female staff so it was almost like an added stress for
15 the men if mostly women were on shift. It was a tense 10:27
16 ward to work on as it had so much potential for serious
17 incidents."

18

19 You remember on a number of occasions telling the
20 nursing officer you were not taking the keys to take 10:28
21 charge of the ward as it felt so short staffed it was
22 dangerous. You would have received staff fortunately,
23 but this would have been at the expense of another
24 ward. So in fairly marked contrast to your memories of
25 Greenan which are good, you describe Moylena as okay, 10:28
26 but also as tense.

27 A. Mhm-mhm.

28 45 Q. How could it have been improved, thinking back to it?

29 A. That's a hard -- I'm not sure -- I suppose like

1 anywhere if we had of had enough staff to carry out
2 activities with the patients. So my later time in
3 Moylena we then got access to the hospital bus and we
4 were able to take people out, and it was, you know,
5 there was a noticeable difference that people weren't 10:28
6 under as much pressure, patients and staff included in
7 that. So I suppose probably if we had of had more
8 staff. When I first went over the staff that were
9 there, I don't know, I don't know if they were
10 inexperienced or not running a ward, and that 10:29
11 potentially led to a lot of chaos, because they might
12 not have -- well they didn't have the experience of
13 running the ward, and when I first went over a lot of
14 the Staff Nurses were sort of preoccupied by sort of
15 hanging out in the nursing, in the office of the ward 10:29
16 which we wouldn't have done in Greenan, so I was a bit
17 baffled about that.

18 46 Q. Can you tell us more about that?
19 A. Yeah.

20 47 Q. When you say "hanging out in the office", what does 10:29
21 that mean?
22 A. You would have found like a concentrated number of
23 staff in it. When I first went over I -- there would
24 have been like a concentrated, there would have been
25 about three or four Staff Nurses in the office. The 10:29
26 office wouldn't have been much bigger than this desk.

27 48 Q. Yes.
28 A. And I remember that being a bit of an issue because it
29 would have always been a discussion who was qualified

1 the longest would have taken charge, and I remember
2 this one day I was walking past, I had a patient and I
3 was walking past, and they found out that I had been
4 qualified longer, so then they were like up in arms
5 that I should have been taking charge and they were 10:30
6 kind of like huffing that I should have been taking
7 charge, but I had said I was -- that was my first day
8 on the ward, I wasn't taking charge of the ward, didn't
9 know the patients, couldn't possibly administer
10 medication to people that I didn't know, and I wasn't 10:30
11 doing it. So there was a bit of a discussion, because
12 I had said then to the Charge, or the Deputy Charge at
13 the time, going 'like that's crazy that they're all
14 sitting about in the office', do you know. I was on a
15 Level 3 of a patient that I didn't really know, getting 10:30
16 slapped, and bit, and punched, and they were all just
17 sort of sitting there.

18 DR. MAXWELL: what were they doing?

19 A. I don't know.

20 DR. MAXWELL: So there is quite a lot of 10:30
21 administration. We've heard from other witnesses that
22 there were no administrative support. A lot of wards
23 would have a ward clerk.

24 A. We would have had a ward clerk. There was two girls
25 that did it, but they wouldn't have been every day, but 10:31
26 they would have been -- they would have come over or
27 they would have come over and collected the work that
28 needed done and would have went over to the admin
29 building, because M4's office wasn't that big, so they

1 wouldn't have had -- but we would have had a ward clerk
2 in Greenan then, they were part-time because they were
3 shared with other wards, but they were -- we had --
4 they weren't called "ward clerks", but they were, do
5 you know. I can't think of what they were called, but 10:31
6 they were...

7 DR. MAXWELL: Okay. Okay. So if I had been there and
8 I had asked these people who were hanging about in the
9 office, what would they have said they were doing?

10 A. I couldn't possibly say. I do recall -- 10:31

11 DR. MAXWELL: You didn't justify it? You didn't ever
12 challenge them?

13 A. No, as said -- well, I did. I says "I don't know what
14 you are sitting in there for?", and then they all
15 muttered something, and I thought on my first day I 10:31
16 didn't really sort of want to fall out with everybody,
17 but I do recall being in M4 that in the evening time I
18 had got all the nursing notes done, incident forms, and
19 the handover done, and come back around the ward to see
20 if everything was all right, because M4 was locked, but 10:32
21 where the office was was on the corridor and then there
22 was a corridor and then a locked door and then
23 different doors to different day rooms, so you were
24 very far removed, so I would have went around to make
25 sure everything was alright, you were in charge of the 10:32
26 ward and you needed to see the people, and I would have
27 walked around, and I remember one of the nursing
28 assistants saying to me, it was like "what are you
29 doing? Have you not loads of paperwork to do?", and I

1 was like "No, it's done." But I think there was
2 potential that they were maybe taking advantage of
3 sitting in the office maybe. I don't know. But, yes,
4 we did have a lot of like, you know, we would have had
5 load of incidents forms, we would have had to do all 10:32
6 the ward report, and we would have had to do, would
7 have had do, but you got them done.

8 CHAIRPERSON: Can I just take you back to the beginning
9 of your answer some time ago now about when you got
10 access to the bus? 10:32

11 A. Yeah.

12 CHAIRPERSON: And you said that the behaviour of the
13 patients changed quite noticeably, and it may be
14 obvious, but was that your experience that when you had
15 something to do with the patients, such as taking them 10:33
16 out on the hospital bus, that would possibly reduce the
17 aggression and the difficulties?

18 A. Well on that particular ward there was. I felt that,
19 you know, they were a bit happier they knew they had
20 something to look forward to, they were getting out, 10:33
21 you know, it might have been only going and getting
22 ice-cream or going -- we would have went maybe to
23 Antrim Gardens and would have went for a walk around
24 there and got a cup of tea and a bit of shortbread, you
25 know, but if I -- just if anybody had something to look 10:33
26 forward to it was maybe a wee bit more pleasant for
27 them. I remember trying to do arts and crafts on that
28 ward, but it didn't go down too well, so there was
29 other things tried, but the bus seemed to be the best

1 thing.

2 CHAIRPERSON: And the same patients who might be

3 aggressive and difficult, for want of a better word, on

4 the ward, when you took them out on a bus, or you gave

5 them something to do, would that aggression diminish or 10:34

6 disappear?

7 A. It probably depended. I can think of a couple of

8 occasions there would have been -- a couple of the

9 patients that you would have took out on the bus by

10 themselves, you know, or there would have been ones 10:34

11 that you could take a couple out, but there would have

12 been one that we would have come back early because

13 there was potential of causing harm.

14 CHAIRPERSON: So it wasn't always entirely successful?

15 A. No, no, it wasn't. Like, you know, you could say like 10:34

16 a good lot of the time it was, but like there was a

17 number of occasions having to come back to the ward

18 early because somebody just wasn't enjoying it, or

19 maybe, do you know, whatever was happening, so they

20 would have had to come back to the ward earlier. 10:34

21 CHAIRPERSON: Yes. Thank you.

22 49 Q. MR. McEVOY: You gave the example of arts and crafts

23 and it not going down well. Who did it not go down

24 well with?

25 A. Oh, some of the patients. He toppled the table. So we 10:34

26 -- just it was something to try, because he didn't want

27 to go out on the bus and he didn't want to go walking,

28 and it was on the run up to Christmas, so I was like

29 "Sure we'll make Christmas trees", and he toppled the

1 table.

2 50 Q. Right. What did you have in Moylena? Did you have
3 access to behavioural support?

4 A. Well, there would have been the behaviour team.

5 51 Q. Yeah. 10:35

6 A. So I suppose as learning disability nurses we were
7 expected to have a certain level of experience or
8 knowledge to work with the patients that are displaying
9 those.

10 52 Q. Yep. 10:35

11 A. So I think it was more down to whatever threshold was
12 hitting to get the behaviour specialists in.

13 53 Q. Yes.

14 A. I don't really recall them being on M4.

15 54 Q. Does that mean that the threshold wouldn't have been 10:35
16 reached?

17 A. Yeah. Yeah, yeah. That they might not necessarily
18 have been hitting the threshold. Yeah.

19 55 Q. Okay. You then say that in Greenan Ward the rate of
20 incidents occurring -- I'm at paragraph 16, thank you: 10:35
21

22 "...was so low that I cannot recall any incidents
23 happening during my time there. There was a patient
24 who had psychotic tendencies and he was detained under
25 the Mental Health Order. She would talk about staff 10:36
26 member's personal lives and make comments, but that was
27 about the worst of what would have happened on Greenan.
28 Other patients on Greenan were voluntary and not
29 subject to the order and were awaiting suitable

1 community placements."

2
3 Then you say:

4
5 "As an example of good care towards a patient in 10:36
6 Greenan, I recall a female patient who was fed in a
7 chair in the day space and required assistance for
8 feeding."

9
10 You were her named nurse: 10:36

11
12 "The patient would not move all day from this chair
13 except to go to bed and to toilet. She would go to day
14 care but not always want to say. Over a long period of
15 time, possibly matter of weeks..." 10:36

16
17 - yourself and other staff managed to get her to the
18 dinner table and eventually she was able to feed
19 herself.

20 10:36
21 "This involved all staff ensuring no other patient or
22 crockery was on the table, as on many occasions she
23 would have pulled the tablecloth off or knocked things
24 off the table. It took time and patience to work with
25 her and encourage her to be comfortable at the table 10:37
26 and eventually feed herself. After some further time
27 she was even able to walk up and down the ward and
28 communicate to ask for things. It was not very often,
29 so when she asked for things we ensured she got them,

1 no matter what she requested, and this was done to
2 encourage her to speak and express her wishes. It was
3 very helpful when she was resettled into the
4 community."

5
6 You then describe how this patient would wear polyester
7 onesies, or even a T-shirt which had to be stitched to
8 her trousers, as she would strip off several times a
9 day, and as a ward you were trying to move away from
10 this, so as her named nurse you purchased a variety of
11 clothes you felt would have met her sensory needs, and
12 you brought clothes that could be layered, but not too
13 heavy, and:

14
15 "The stripping incidents were not totally eradicated
16 but were reduced, and H154 was happy with that and
17 supported it, as it was very person-centred."

18
19 And you eventually got the patient to wear socks and
20 shoes to day care.

21
22 So that good care example shows an improvement in
23 eating, walking, communicating, and less of the
24 stripping behaviour. Was that based on your own work
25 and your own observation, or had you input and
26 assistance from other professionals?

27 A. No, that was just cause I was her named nurse and she
28 would have been sitting in what would have been called
29 like a tub chair, it was big sort of like half moon

1 chair, and she would have been sitting with her wee
2 knees up to her chin nearly, so I just thought I'm not
3 feeding anybody like that, you know.

4 56 Q. Yes.

5 A. So it was kind of like at a ward level we said, 'well, 10:38
6 no, actually we're going' -- and that's kind of what --
7 there wasn't really any input from other professionals
8 for that, that was just something that we were doing at
9 ward level.

10 57 Q. So that's the feeding. What about the other aspects 10:38
11 that you have described, the walking and the speaking
12 and all of those things?

13 A. Well, with the walking just it was basic a nursing
14 things, she should have been doing a wee bit of
15 exercise or a wee bit of movement. Her wee joints 10:38
16 would have been really stiff from sitting. So we would
17 have got her like -- she sort of -- she would have took
18 you by the hand and she would have walked wee bits and
19 would have got better over a period of time. But I
20 suppose she did have a wheelchair for transporting. 10:39

21 58 Q. Yeah.

22 A. So -- but there was no input, and I suppose I didn't
23 feel there would have been any need for any other
24 professional input for those sorts of things. Like as
25 registered nurses we would have been more than capable 10:39
26 of doing that.

27 59 Q. Okay. And in terms of the clothing, if I can call it
28 the all-in-one clothing, or the onesies, had that been
29 common? I know you had your student placements there,

1 but do you know pre-2013, was that something --
2 A. I suppose it probably would have been common at a time.
3 As the years went on as a student and as a Staff Nurse,
4 it was something that there were -- like the majority
5 of them moved away, but this particular lady she 10:39
6 wouldn't tolerate anything else, she was so used, you
7 know.
8 60 Q. Yes.
9 A. It probably would have been more common as a student to
10 see the polyester jammies, not everybody was in the 10:39
11 all-in-ones. The all-in-one would have been more to
12 prevent somebody from picking at their pad, and
13 potentially if somebody had PICA or anything.
14 61 Q. Yes. Yes.
15 A. But not everybody would have been in an all-in-one, but 10:40
16 they would have, likely when I was a student, would
17 have all had the polyester jammies.
18 62 Q. And you've described what you did in terms of going to
19 get -- purchasing a variety of alternatives?
20 A. Yeah. 10:40
21 63 Q. Can you tell us a wee bit more about that and how you
22 went about that process?
23 A. Yeah. So as a named nurse we would have had the
24 responsibility of purchasing the patient's belongings,
25 their clothes or whatever. So I went -- I think I went 10:40
26 to Marks & Spencers and got like the elasticated
27 waisted trousers, that they were still -- they looked
28 like trousers. They were like -- I got all different
29 ones. But got those. Got like jeggings. They looked

1 like jeans, but they were soft and stretchy. And it
2 was kind of like an exposure type thing, we kind of put
3 them on her in the morning and she got used to them,
4 and then to the point that she tolerated them. But I
5 would have been buying stuff that was sort of like more 10:41
6 modern, but like trendy, but age appropriate for her in
7 particular. She was very small, so it was difficult to
8 get some of the clothes. But you would have got stuff
9 -- we would have sent it over to laundry and would have
10 got it mended if we needed things shortened or 10:41
11 whatever.
12 64 Q. Yes. Yes.
13 A. So I just, I just purchased things that I thought were
14 sort of -- that she might like. And once we got sort
15 of established that she liked the black trousers and 10:41
16 like the jegging type ones, we then went -- well I went
17 and got sort of more similar type of the clothing.
18 65 Q. Softer material?
19 A. Yeah, yeah, yeah. But still like, not like joggers or
20 anything. 10:41
21 66 Q. Yes.
22 A. But still sort of to be sort of respectful?
23 67 Q. Did you think that the material in the onesie, the
24 polyester material, that the patient disliked?
25 A. No, I think she did like it. I think she liked it. 10:41
26 And that's why then we -- when I got -- actually then
27 around that time I think the fancy onesies for jammies
28 came out.
29 68 Q. Right.

1 A. So we were able to get like fleecy ones and nicer ones.

2 69 Q. Yes. Yes.

3 A. We didn't try her with pyjamas because it was kind of
4 night-time, she would have really like pulled the pad
5 apart and would have been eating it. I suppose if I
6 had of been there longer, or she, you know, she could
7 have moved out to the community and have maybe moved on
8 to pyjamas, but as sort of time went on, we didn't have
9 the time.

10 70 Q. Yes.

11 A. We were sort of concentrating on the clothes and the
12 socks and shoes.

13 71 Q. Okay. I think you possibly have answered this question
14 already, but those decisions that you took on behalf of
15 -- in care of this patient, were those based solely on 10:42
16 your own initiative or was there input from any other
17 professionals?

18 A. Well I suppose the responsibility of the named nurse is
19 ensuring that your patient, the patient that is
20 allocated to you has enough clothes, has enough of 10:42
21 their personal items. So I suppose it was kind of
22 like, it was my responsibility as a named nurse to
23 ensure that she had appropriate clothing, and with the
24 view of her going out into the community, into the
25 nursing home, that it would have been more appropriate 10:43
26 that she was wearing nicer clothes and getting used to
27 it.

28 CHAIRPERSON: Can I just ask how many patients you have
29 been named nurse for?

1 A. Five to six maybe. That was on our ward. That would
2 have been sort of standard.

3 72 Q. MR. McEVROY: Okay. I want to move on now and ask you
4 about paragraphs 18 and 19 of your statement. All
5 right. Now this is -- these paragraphs concern an
6 incident of, the only one incident of poor care that
7 you witnessed on Greenan, and just to orientate us in
8 time, I think you say earlier on in your statement you
9 were in Greenan from early 2013 to late 2014, would
10 that be right?

11 A. Yeah. Yeah.

12 73 Q. So some time in that period. Okay. You have
13 identified, and I think he has a cipher of P227 as a
14 male patient, and we just know it is just his first
15 name that you've given.

16 A. Okay.

17 74 Q. Now, I don't want you to tell us his full name if you
18 know it. Okay? I don't want you to tell us, but just
19 simply "yes" or "no", do you remember his surname?

20 A. Oh, yes. Yes.

21 75 Q. You do. Okay. Could you write it down for us, do you
22 think?

23 A. Yes.

24 76 Q. The secretary will give you a piece of paper.

25 CHAIRPERSON: I think the Panel would like to see it as 10:44
26 well, please.

27 INQUIRY SECRETARY: Two seconds and I'll just get the
28 --

29 CHAIRPERSON: Okay. Just to explain. There are

1 reasons why the identification of this patient could be
2 sensitive, so we're just going to leave it at the
3 cipher at the moment.

4 MR. McEVOY: what we can indicate, and you don't need
5 to worry about this, but I think what we can indicate
6 for the record is that that person has also another
7 cipher which is known to the Inquiry. We can say that.

10:45

8 CHAIRPERSON: Yes.

9 77 Q. MR. McEVOY: Now, this person, male patient, required
10 two-to-one supervision as he had mobility issues which
11 prevented him from being able to support himself, and
12 you say that the two-to-one supervision was carried out
13 by we'll say two staff members who weren't nurses. I
14 think we can possibly say that?

10:46

15 A. Mhm-mhm.

10:46

16 78 Q. And/or by Band 5 Staff Nurses, and on this particular
17 occasion then that you describe, you were carrying out
18 a walk around on the ward with another member of staff,
19 when you were passing that male patient, and then two
20 members of staff, not nurses, who you have identified,
21 and you saw one of them squirt water into the face of
22 that patient and onto his body, and he was visibly
23 soaking, and there was no reason for that staff member
24 to have done it. You challenged the two staff members,
25 not nurses, on this, and they said it was only a joke
26 and suggested that they could tell others that he had
27 wet himself, and yourself and your colleague took the
28 patient and got him cleaned up and "once we got that
29 patient cleaned up" you rang the night charge who

10:46

10:47

1 advised you to ring the senior manager who was on-call,
2 and that was H77, and you did that and you told H77 --
3 I beg your pardon -- about the incident, and both H77
4 and H507, the Service Manager, met with you the
5 following morning and the incident was reported to the 10:47
6 police and they took a statement?

7 A. Mhm-mhm.

8 79 Q. Okay. When you moved from Greenan to M4, one of those
9 staff members who you have described, not nurses, had a
10 family member who was banked on M4, and you say it was 10:47
11 not comfortable for you initially working in the ward
12 with all the chatter about you work making a report
13 when you worked in Greenan, as that member of staff had
14 been suspended as a result of your report of the
15 incident with the male patient. You recall a male 10:48
16 nursing --

17 CHAIRPERSON: I'm so sorry to interrupt, but before you
18 go on there's just a couple of questions while it is
19 still fresh in our mind that I want to ask about the
20 incident, without obviously naming anybody, but you say 10:48
21 you were effectively walking past?

22 A. Yeah.

23 CHAIRPERSON: would it have been obvious to the care
24 assistants involved that you were walking past?

25 A. Maybe not. I couldn't say, but I don't think so. I 10:48
26 don't know.

27 CHAIRPERSON: Right. Okay. But at the time you did
28 challenge them?

29 A. Yeah.

1 CHAIRPERSON: And they didn't seem to see very much
2 wrong with what they had done?

3 A. No, they thought it was funny.

4 CHAIRPERSON: Yes. Okay. Thank you. Sorry,
5 Mr. McEvoy, but I didn't want to lose that moment. 10:49

6 DR. MAXWELL: Can I just follow up then? So we have
7 heard of occasions where people thought what they were
8 doing was acceptable, was banter, and clearly it
9 wasn't. In response to this incident, was there ever
10 any sort of reflection with the ward team from the ward 10:49
11 Manager or senior nurses, without going into details of
12 who was involved, to say 'Just to be clear, this sort
13 of behaviour is always unacceptable'?

14 A. No, I think knowing the patient that it was, you know,
15 I take what you're saying about the banter, but there 10:50
16 would have been maybe more able patients. But he -- I
17 don't -- there wasn't ever anything. I don't think
18 there was ever any question that.

19 DR. MAXWELL: And not in relation to him.

20 A. Oh, in general? 10:50

21 DR. MAXWELL: So it points to the idea that actually
22 some of the health care assistants at least thought
23 this sort of behaviour was acceptable, I don't know how
24 many, it might have just been these two, maybe more.
25 In response to that, not managing those people, was 10:50
26 there ever anything from the ward sister or the Senior
27 Nurse to say 'This isn't acceptable. It's come to our
28 attention that some people think this is acceptable.
29 We're laying down a marker now, this is always

1 unacceptable'.

2 A. I don't recall.

3 DR. MAXWELL: You weren't aware of that of anything

4 like that?

5 A. I don't think so. No. 10:50

6 CHAIRPERSON: You're going to come on, I think, to the

7 proceedings that took place afterwards, but so far as a

8 general declaration, as it were, to the staff on the

9 ward, you don't remember anything being done?

10 A. No. 10:51

11 CHAIRPERSON: Mr. McEvoy.

12 MR. MCEVOY: Those members of staff, not nurses,

13 working at a lower level, I think we can be clear about

14 that, not in the nursing profession I think we've

15 indicated, as a Band 5 nurse and someone working as a 10:51

16 named nurse indeed on the ward, was it, was it easy to

17 challenge the practice? This topic may have already

18 been covered. Was it easy to challenge the practice of

19 those type of staff? Did you feel it was easy to

20 challenge the behaviour of those type of staff? 10:51

21 A. It wasn't easy, but I had to do it, do you know. I

22 couldn't possibly have not. It was, I suppose it was

23 difficult, but there was no way you could -- not in a

24 million years would I have walked past that and not

25 challenged it. 10:51

26 DR. MAXWELL: Can I just ask you a little bit about

27 that, because we know in other settings, often the

28 health care assistants or Nursing Assistants, or

29 whatever we're calling the Band 3s, have been there a

1 long time, longer than the Staff Nurses. How did they
2 see Band 5s? Did they see you as senior to them or did
3 they just think you were transient people?

4 A. I suppose it depended. There would have been ones have
5 been like 'Oh, I've been here for 20 years', you know, 10:52
6 and there would have been ones -- there would have been
7 Band 3 you'd have put your live in their hands that you
8 would have known that they be really, really good and
9 really good members of staff. There would have been
10 ones going, do you know, 'You're only newly qualified, 10:52
11 what would you know?'. But at the end of the day I had
12 a professional registration to uphold.

13 DR. MAXWELL: Absolutely.

14 A. And when I had worked -- my first job when I qualified,
15 I did have a bit of a difficult time and I just 10:52
16 thought, do you know, I am not prepared to lose my
17 nursing registration, you know, and I think that's --
18 you know, I didn't really care what anybody -- to an
19 extent I obviously was emotional, I felt, but at the
20 end of the day I would have had to stand over my NMC 10:53
21 registration, and as difficult as it was --

22 DR. MAXWELL: But it was difficult to do.

23 A. Oh, it was. Aye. Yeah. But, do you know, it was
24 something that needed done, but it wasn't easy, no.

25 80 Q. MR. McEVOY: And just on that very point. You describe 10:53
26 how you recall a male nursing assistant, you don't
27 recall his name, saying to you that he heard you were a
28 tout, but that you didn't seem that bad. Was that sort
29 of behaviour and those sort of words, was that common

1 in Muckamore?

2 A. No, that was kind of the first time that I would have
3 sort of ever experienced that. You know, going from
4 Greenan, like it was lovely, and going to that, that
5 was the first time, and thankfully the only time I ever 10:53
6 experienced that. I suppose, I don't know what other
7 people experienced, but that was -- like I don't know
8 if that was the norm or like -- that was my difficulty
9 when I first went to M4, and I would imagine maybe some
10 of the chatter in the office when they were hanging 10:54
11 about was that I was one of them, you know, the one
12 that was telling tales or carrying stories, so it was,
13 it was difficult. But that was -- like, do you know, I
14 was doing the right thing, so I didn't really care what
15 he had to say, but that was the only time I had ever 10:54
16 experienced that.

17 81 Q. Had you heard of others having a similar experience,
18 others who may have spoken out?

19 A. I didn't know of any other people that had reported
20 anything. 10:54

21 CHAIRPERSON: But there was an individual who said that
22 to you.

23 A. Mhm-mhm.

24 CHAIRPERSON: But were you aware of others by the way
25 they treated you. 10:54

26 A. Yeah. Oh, yeah.

27 CHAIRPERSON: A similar view.

28 A. No. Yeah. My first day in M4 was a long day on a
29 Sunday, and it was the worst long day I could have ever

1 have put in.

2 CHAIRPERSON: Because there was...

3 A. Yeah, like, you know, I was excluded. Like I went

4 looking for somebody. I was on Level 3 for hours and

5 hours, and I went looking for somebody to say 'Is 10:55

6 somebody going to take him so that I can go to

7 toilet?', or 'Is there no lunch breaks?', you know, 'Do

8 you not do tea breaks here?', and sort of making them

9 have to take -- give me a break. Yeah. No, it was...

10 CHAIRPERSON: And what happened about that? 10:55

11 A. Oh, no, they had to give me a break. They had to.

12 CHAIRPERSON: Right.

13 A. So they took this particular patient, and then in the

14 p.m. I says I wasn't taking him because I didn't know

15 him well enough, and I felt that I was irritating him 10:55

16 more, and therefore I was then getting -- like he had

17 these things and he was whipping me with them and he

18 was hitting me, and I just thought somebody knows him

19 better that's not going to be irritating him, so I said

20 in the afternoon very strongly that I wasn't taking 10:55

21 him.

22 CHAIRPERSON: But there was -- it sounds as if the

23 issue was not around that patient specifically, but

24 around offering you support.

25 A. Yeah. No. Yeah, it was a very difficult 13-hour 10:56

26 shift.

27 DR. MAXWELL: And was that hostility from registered

28 nurses as well as health care assistants?

29 A. Everybody on the ward.

1 DR. MAXWELL: So registered nurses as well. They knew
2 that you had -- well...

3 A. Well I perceived that I was being -- like if somebody
4 new had of come to my ward I wouldn't have been
5 treating them the way I was treated. So I just felt 10:56
6 that it was -- and then off that comment of being a
7 tout, is what I felt then that was what the chatter
8 was, because I was aware that there was a lot of
9 talking around the hospital. Everything goes, do you
10 know, everything was being told. 10:56

11 PROFESSOR MURPHY: So it must have been very difficult
12 going back the next day. How did you win them round?

13 A. I didn't win them round. I just went and did my work.
14 I just went and did my work and, do you know, as I said
15 before I have a registration, I am a registered nurse, 10:57
16 I had a job to do, and that was their problem, and I
17 didn't feel that I needed or could have challenged
18 absolutely everybody, because then I probably would
19 have been perceived to be the problematic one. But I
20 think as time went on and I was on the ward and just 10:57
21 getting on with my work, I think then people just seen
22 who I was, and that I wasn't so much of an issue. And
23 then the other person's relative stopped banking on the
24 ward, which alleviated a lot of pressure, a lot of like
25 whispers, sort of, whatever it would be called sort of, 10:57
26 like that kind of eradicated that, and then people just
27 -- we had too much work to be doing, to be honest, well
28 I felt, to be caring what they thought, you know. So I
29 think in time that they kind of just got over it and

1 moved on, because it wasn't...

2 CHAIRPERSON: Are you going to move on to the

3 proceedings that followed?

4 MR. McEVOY: Yes, I am, Chair.

5 CHAIRPERSON: How long is that going to take us? I'm 10:57

6 just thinking about the witness.

7 MR. McEVOY: Yes, I think it might be a good moment. I

8 have one question just before we leave and then we can

9 possibly look at a break.

10 CHAIRPERSON: Yes. Okay. 10:58

11 MR. McEVOY: You had described, earlier in your

12 evidence you had described the contrast, and taking you

13 to the contrast between your Greenan experience and

14 your Moylena experience. You describe it as "okay",

15 you describe it as "tense", and I took you through all 10:58

16 of the reasons why you described that in terms of

17 staffing levels and responsibilities. Would it be fair

18 to say that the fact that you had made this report was

19 also possibly a factor and why you found it tense in

20 Moylena? 10:58

21 A. Oh, yeah, 100%, yeah.

22 MR. McEVOY: Okay. We could possibly take a pause

23 there, Chair?

24 CHAIRPERSON: We normally take a break. You've been

25 going about an hour. 10:58

26 A. Okay.

27 CHAIRPERSON: It might feel longer, it might feel

28 shorter to you, I don't know. But we'll take a 10/15

29 minute break.

1 A. Okay.
2 CHAIRPERSON: I think somebody will get you a cup of
3 tea and we'll see you back -- don't discuss your
4 evidence with anybody and we'll see you back in 15
5 minutes. 10:58
6 A. Thank you.
7 CHAIRPERSON: Thank you very much everybody.
8
9 SHORT ADJOURNMENT
10 10:58
11 THE HEARING RESUMED AFTER A SHORT BREAK AS FOLLOWS:
12
13 CHAIRPERSON: Thank you. Yes.
14 MR. McEVOY: Chair, Panel members, just before we
15 proceed, you will recollect that in the previous 11:20
16 session in the earlier part of the session, I asked the
17 witness whether she could give the surname of P227, and
18 for the benefit of the Core Participants and anyone who
19 may be following proceedings, the Inquiry team will
20 follow up with that identification and further 11:20
21 communication about it may follow as necessary.
22 CHAIRPERSON: Yeah. I mean I think it's obviously
23 important for CPs particularly to know...
24 MR. McEVOY: Absolutely.
25 CHAIRPERSON: If at all possible to be told who that 11:20
26 is.
27 MR. McEVOY: Exactly.
28 CHAIRPERSON: Okay.
29 82 Q. MR. McEVOY: So H324, we were just about to come on to

1 the aftermath of your report of that incident that we
2 looked at, and as far as you're aware then you
3 recollect that one of the staff members was suspended
4 and you then had to go and attend a hearing.

5 A. Yeah.

11:21

6 83 Q. In relation to the investigation. Turning overleaf now
7 to page 8. And you recall this about the hearing then:

8
9 "There was a Band 8B from the community and H758
10 present to Chair the hearing. From memory there were
11 two others with him on the Panel..."

11:21

12
13 - but you don't remember their names. Also in
14 attendance was H77, yourself, staff member, and their
15 union rep. You weren't given any information prior to
16 the hearing about its structure, and you say it was
17 awful, and you weren't expecting that staff member, who
18 was the subject of it, to be there in such close
19 vicinity to you. You remember that you sat beside one
20 another and you remember that staff member saying that
21 what they had done to the patient was a joke. They
22 denied it was intentional. And you recollect then H758
23 asking you questions. You don't know why you were all
24 in the same place together, but you know now that from
25 a safeguarding point of view that's not how it should
26 have been done.

11:21

11:22

11:22

27
28 Perhaps the answer to this question is somewhat
29 self-explanatory, but what was it about the hearing

1 that was awful? what in particular?

2 A. Going into the room, seeing the person, and then being

3 sat beside the person. Their union rep was quite

4 aggressive and, to be honest, I was quite blind-sided.

5 H77 had sort of said that I would be going in and sort 11:22

6 of chatting or discussing with the Panel, like with the

7 safeguarding panel, and he himself wasn't aware that

8 that was going to be the setup.

9 84 Q. Yeah.

10 A. So I was quite blind-sided. Something that was really 11:23

11 really stressful and difficult to manage and then being

12 sat down beside her was...

13 CHAIRPERSON: So can I ask you a bit more around it?

14 Did you have to write anything down or make a report

15 before the hearing? 11:23

16 A. Not that I recall. I remember I had to do a statement.

17 So I had to do a statement for the Trust.

18 CHAIRPERSON: Right. Okay. Yeah.

19 A. But I don't recall at that time doing any writing, but

20 I think... 11:23

21 DR. MAXWELL: Did you fill in an incident form?

22 A. Oh, yeah. Yeah.

23 DR. MAXWELL: You did.

24 A. Yeah, yeah. So the evening that that happened there

25 was an incident form filled out, and that was all 11:23

26 documented in the daily notes, that was we were doing

27 paper notes then, so that would have been documented

28 with the number of the incident form, whatever the --

29 we would give --

1 DR. MAXWELL: Did you write in the patient's notes?

2 A. Yes.

3 DR. MAXWELL: You did.

4 A. Yeah.

5 DR. MAXWELL: Okay. 11:23

6 CHAIRPERSON: And were you asked to say anything? Did

7 you have to speak at the hearing?

8 A. I can't really remember. I think I had to sort of say

9 what had happened or my, do you know, I think that's --

10 I can't really remember, but I think it was more kind 11:24

11 of just sort of going over what had previously been

12 said in the statement.

13 CHAIRPERSON: And did you have any support from anyone

14 at the hearing.

15 A. Well, H77 was very supportive at that time, but I 11:24

16 suppose I kind of was a bit green, for the want of a

17 better word, then I didn't really know what to expect,

18 so I kind of just went in, took H77 at the word of like

19 'this is going to be fine, this is standard, don't be

20 worrying about it', so I didn't feel that I like 11:24

21 probably -- I don't know, but I don't think I needed

22 anybody.

23 CHAIRPERSON: And just finally, where did the hearing

24 take place?

25 A. In the admin building in the hospital grounds. 11:24

26 CHAIRPERSON: Within Muckamore?

27 A. Mhm-mhm. Yeah.

28 CHAIRPERSON: Okay. Sorry to interrupt. Thank you.

29 85 Q. MR. McEVOY: Just picking up with the Chair's question.

1 You say in your statement that H758, who was I think
2 the Chair, asked you questions at the hearing.

3 A. Mhm-mhm.

4 86 Q. What were the -- can you remember anything about the
5 tone of the questions, the way they were asked? 11:25

6 A. No, I think -- from memory I think like there wasn't
7 anything, it was just sort of more 'can you explain, or
8 can you tell me?', I think it was more that sort of,
9 'you've said here, what about', you know, just sort of
10 explaining over the statement, from memory I think 11:25
11 that's what it was.

12 87 Q. And you told us a moment or two ago that the staff
13 member's union rep was aggressive?

14 A. Yeah.

15 88 Q. How were they aggressive? 11:25

16 A. Just in their mannerisms, like how they were speaking,
17 you know, quite curt like sort of to me, or like
18 proposing that it was a joke and that I was
19 overreacting, you know, things -- like that was the
20 sort of gist. 11:25

21 89 Q. Was that through the Chair as opposed to directly to
22 you?

23 A. Well I was sitting here and those two were sitting
24 there. (Demonstrating). So I kind of felt it might
25 have just been directly at me. It wasn't like 'Chair, 11:26
26 can I say?'. It wasn't that sort of formal.

27 90 Q. Right.

28 CHAIRPERSON: Just for the transcript you're saying
29 you're sitting next to each other.

1 A. Yeah. Yeah.

2 CHAIRPERSON: Yes.

3 MR. McEVOY: I know you they were in close vicinity,

4 but I suppose the Inquiry Secretary --

5 A. If you didn't know -- like I would have been closer to 11:26

6 them than what Jaclyn is to me now.

7 91 Q. Okay.

8 CHAIRPERSON: So within a foot or two?

9 A. Yeah.

10 MR. McEVOY: You say then that staff member was able to 11:26

11 return to work. You don't know what ward that staff

12 member went back to work on...

13 A. Mhm-mhm.

14 92 Q. Or whether any restrictions were put in place for that

15 staff member, but you had an idea that they weren't 11:26

16 allowed to work with that patient again?

17 A. Yeah.

18 93 Q. The other staff member was not suspended, but was moved

19 wards, and you're not sure to where. After the hearing

20 then you recall that H77 got you a cup of tea and he 11:26

21 did that as you were so distressed during the meeting

22 and it was a much appreciated support. You say:

23

24 "The whole incident would have made me never want to

25 report anyone or anything again. Notwithstanding this 11:27

26 feeling I would have reported incidents had I needed

27 to, but thankfully I did not have to."

28

29 So in other words, although it was awful, it didn't put

1 you off your obligation?

2 A. No. As I said earlier I have a registration of the NMC
3 to uphold.

4 94 Q. Yes.

5 A. So no matter how difficult something is, you have to do 11:27
6 it.

7 95 Q. Yes. You go on and you say:

8

9 "If I had been a newly qualified nurse I'm not sure how
10 I would have handled this situation." 11:27

11

12 A. Mmm.

13 96 Q. Can you tell us more about what you mean by that?

14 A. Yeah. I suppose when I first qualified I worked in a
15 nursing home for a 13 months, had a bit of a difficult 11:27
16 time, so probably built a bit of resilience and a bit
17 of managing or dealing with long members of staff.
18 There was a particular -- I'm thinking of one in
19 particular that I did have an issue with a member of
20 staff that had been there for a very long time. So for 11:27
21 the want of a better word, I probably got a bit of a
22 thicker skin to manage these sorts of things. And then
23 when I worked in the community, before I came to
24 Muckamore, I just had had good experience and had good,
25 good examples. Like I worked with good nurses, you 11:28
26 know, so I suppose from then I kind of gathered
27 strength from that, that I had to do the right thing,
28 you know. But as a newly qualified Staff Nurse I would
29 have done it, but I'm sure that I probably would have

1 ended off needing going off work sick with the stress
2 of it sort of thing, you know. But I suppose as time
3 went on I had been -- I think I was qualified maybe two
4 and a half years at this point, I had sort of built
5 enough resolve.

11:28

6 97 Q. Yes. And thinking back to the point you made, I know
7 it's a bit further back up in the same paragraph, but
8 thinking back to the point about safeguarding?

9 A. Mhm-mhm.

10 98 Q. How do you think that the meeting, thinking back on it,
11 should have or could have been better handled?

11:28

12 A. Well from my experience now of working, when I worked
13 in the community we would have been investigating
14 officers with the adult safeguarding.

15 99 Q. Yes.

11:29

16 A. And I have been involved in interviewing staff that
17 have had an allegation made against them, and it would
18 never occur to me to put the staff that made the
19 allegation in with the alleged perpetrators. So from
20 experience now, I don't think -- well that wouldn't be
21 done, but I don't know.

11:29

22 DR. MAXWELL: Can I just clarify? This was a
23 disciplinary hearing, not a safeguarding investigation?

24 A. From my understanding, my memory, I think it was
25 safeguarding, because that H758 was the DAPO at the
26 time.

11:29

27 DR. MAXWELL: So there wasn't a disciplinary hearing
28 that you were involved with?

29 A. Not that I was involved with.

1 DR. MAXWELL: And you think this was?
2 A. Safeguarding.
3 DR. MAXWELL: A safeguarding. And did the safeguarding
4 meetings have hearings normally?
5 A. I'm not sure. This is the only time that I've ever 11:29
6 been.
7 DR. MAXWELL: Okay.
8 A. Unless it was rolled -- like unless it was a
9 safeguarding and a disciplinary into one, but I don't
10 think... 11:30
11 DR. MAXWELL: It seems unlikely because they're two
12 very different processes.
13 A. Yeah, but H758 was -- he wasn't the DAPO at the time,
14 but...
15 DR. MAXWELL: well, we can check. 11:30
16 A. Yeah. Okay.
17 DR. MAXWELL: We can check what the meeting was.
18 100 Q. MR. McEVOY: Yes. And I suppose just to clarify,
19 you've used the phrase throughout "hearing" as opposed
20 to "meeting". 11:30
21 A. Yeah. well that's -- yeah.
22 101 Q. Okay. You have described then in your statement about
23 your recollection from your training at Queen's. At no
24 point in your training at university had we covered or
25 been prepared for conflict within the work place. 11:30
26 A. Mhm-mhm.
27 102 Q. Did you get any -- had you any education, nursing
28 education, about safeguarding and whistle-blowing?
29 A. well we would have had to attend the mandatory training

1 for safeguarding, that would have been part of our
2 mandatory training and part of the induction. When you
3 started you had to get all your mandatory training up
4 to date.

5 103 Q. Was that at Queen's as an undergrad? 11:31

6 A. No, no, as a Staff Nurse.

7 104 Q. As a Staff Nurse. Thinking back though to your
8 undergrad training?

9 A. I'm sure. I couldn't say for definite, but I'm sure we
10 did touch on safeguarding. But, honestly, it's that 11:31
11 long ago I couldn't say.

12 105 Q. And you go on and you say:

13

14 "I think after this incident I attended Belfast Trust
15 training which probably would not have covered the 11:31
16 stress endured being a whistle-blower."

17

18 what was that training?

19 A. I think it was -- to be honest it was that long ago I
20 can't really remember, but I think it was more sort of 11:31
21 your role and responsibility as a member of staff and
22 having to whistle-blow. It wasn't sort of like the
23 emotional support that you would have, do you know, it
24 was probably not, you know, I think from memory it was
25 more sort of like the whistle-blowing policy and you 11:31
26 had a duty to whistle-blow sort of thing, and kind of I
27 think -- I don't remember really what else.

28 106 Q. Yes. Thinking back now to that experience, and I think
29 you've described, you've used the phrase

1 "whistle-blowers" there and training and understanding
2 of whistle-blowing and what it means. Given your
3 experience, are there any steps that you would sort of
4 propose or put forward to make the process more --
5 something that's simpler to understand as a staff 11:32
6 member, and a current staff member the Trust?

7 A. I don't know. I don't know if I could think of
8 something off the top of my head. I think just...

9 107 Q. In terms of the stress, for example, that you
10 encountered? 11:32

11 A. Take some time off! I don't know. I suppose I was
12 kind of lucky in the fact that I did have good
13 emotional support. H188 would have been very
14 supportive.

15 108 Q. Yes. 11:32

16 A. And H77 would have been very supportive. A couple of
17 occasions following that I got phone calls to the ward
18 saying "Come over here a wee minute", and it would have
19 been just to take me off the ward to sort of go over,
20 just as moral support. 11:33

21 109 Q. Yeah.

22 A. And I remember H188 leaving a bar of chocolate on the
23 table as a way of sort of like 'this will be all
24 right', sort of thing.

25 110 Q. Yes. 11:33

26 A. But I'm not sure what, as a current staff, I don't
27 really know how you would ever anticipate that level of
28 stress, you know. I don't know, you know, like if I
29 was to do that next week, I'm not sure I would feel the

1 same stress, or the following week I would feel more
2 stress.

3 111 Q. Yes.

4 A. I'm not sure how you could ever be fully prepared or
5 anticipate the level of stress and sort of like the 11:33
6 consequences.

7 112 Q. Could training and awareness raising about
8 whistle-blowing and the policy, the Trust's
9 whistle-blowing policy, address those sorts of things?
10 Could it address the stress that you might feel? 11:33

11 A. I don't think so. I think I would -- I don't know. I
12 don't think so. I think like it would be very generic
13 sort of 'Whistle-Blowing, this is the policy', you
14 know. Whereas like I might be more emotional today
15 than I would be next week, or somebody else might go 11:34
16 'well, actually, that's my job, I have to do that', do you
17 know. People might be more matter of fact about it.
18 I'm not sure. You know, one size wouldn't fit all. So
19 I'm not sure how you could do that, you know? You can
20 give the basis and sort of the policy, but I'm not sure 11:34
21 how you would encompass people's emotional. I'm not
22 sure how.

23 113 Q. Yes.

24 PROFESSOR MURPHY: Might it have helped though if
25 somebody had spoken to you about what to expect from 11:34
26 the hearing?

27 A. Pardon?

28 PROFESSOR MURPHY: Might it have helped if somebody had
29 spoken to you about what to expect from the hearing?

1 A. Yes.

2 PROFESSOR MURPHY: Because it sounds like you didn't

3 have any preparation for it.

4 A. H77 had said, 'well, we're going in here H758 will just

5 be asking you a couple of questions. It'll be 11:34

6 basically on your statement. Like it'll be fine. It's

7 just sort of more of a straightforward thing here,

8 don't be worrying about it', so at that level I kind of

9 thought 'well, this is just something straightforward.'

10 Had I of known that the other people were going to be 11:34

11 in the room it would have been slightly different and

12 possibly needed more preparation or support around

13 that. But H77 stated at the time that he was as

14 shocked to see the people as I was.

15 CHAIRPERSON: There seemed to be two sides to this, 11:35

16 that if you were less resilient might have put you off

17 reporting anything again. One was the immediate

18 reaction.

19 A. Yeah.

20 CHAIRPERSON: After you had called this out, from other 11:35

21 members of staff, almost, you say all other members of

22 staff on the ward. And the second was the way that you

23 were treated, or the surprise that you got at the way

24 that the hearing, whatever the hearing was, was

25 conducted. 11:35

26 A. Mhm-mhm.

27 CHAIRPERSON: Is that fair?

28 A. Sorry, what was?

29 CHAIRPERSON: So there's the two aspects that have so

1 troubled you.

2 A. Oh, yeah, addressing it and then -- yeah, yeah, sorry,

3 yeah.

4 CHAIRPERSON: Yeah. And you said well, you know,

5 you're quite resilient now and because you're 11:36

6 registered you would certainly report something again.

7 A. Mhm-mhm.

8 CHAIRPERSON: But it may follow from that, that a less

9 resilient person, whether registered or not, might be

10 put off. 11:36

11 A. I could see why people would be put off. I would be

12 disappointed though if they weren't, you know, when

13 you're working in learning disability you're advocating

14 for the vulnerable people, do you know, that you're

15 working with, and I'd be really disappointed if people 11:36

16 didn't. And I suppose having the nursing registration,

17 you have to do it, whether it's a nice experience or a

18 terrible experience. I could see why people would be

19 put off, but I don't see why they would be working in

20 that field if they wouldn't be advocating for their 11:36

21 patient to the best of their ability.

22 CHAIRPERSON: But you did say that it was both

23 unregistered and registered people who reacted badly

24 towards you, or poorly towards you.

25 A. Mhm-mhm. 11:37

26 CHAIRPERSON: When you returned to the ward.

27 A. Yeah.

28 CHAIRPERSON: Can I just ask this about

29 whistle-blowing? Was there anybody that you were

1 given, as it were, to go and speak to if you did have
2 any safeguarding concerns?

3 A. The H188 was the safeguarding officer for our
4 particular ward.

5 CHAIRPERSON: So that's who you would automatically. 11:37

6 A. Yeah. Yeah. And then you would have phoned and then
7 says that you're putting -- if there was an issue -- I
8 can't remember what the form was, but it would be an
9 APP1 now. I can't remember what it was called then.
10 But you would be phoning and discussing it to make sure 11:37
11 if it is an appropriate referral to put it in. But
12 like H188 would have been very, he would have been a
13 good point of contact.

14 CHAIRPERSON: Okay. Thank you.

15 114 Q. MR. McEVOY: Just before we leave this point and I 11:37
16 think it already has been touched on, but you say that
17 you were lucky to have H188 and H77 as people to give
18 you moral support, as you described it. And I suppose
19 in other circumstances you might not have been so lucky
20 to have had those people as your managers to speak to. 11:38

21 A. H77 wasn't my manager.

22 115 Q. Of course.

23 A. It was just I needed support and I was ringing him, do
24 you know.

25 116 Q. Indeed. You were fortunate just to have access to 11:38
26 those people?

27 A. Yeah. Yeah.

28 117 Q. If you hadn't been so fortunate might it have changed
29 your view about the experience?

1 A. well, it probably would have been much more negative
2 view on it.

3 118 Q. Okay. Leaving that issue for now then, you go back to
4 talk about the atmosphere on the wards. You say it was
5 generally good but always depended on people. I'm at 11:38
6 paragraph 20 now at the bottom of page 8:
7
8 "Some staff would be worriers."
9
10 would you describe yourself as a worrier? 11:38
11 A. Not really.

12 119 Q. Okay. What would they be worrying about?
13 A. Well I think when I was making that comment I was
14 thinking of a couple of people would have been worrying
15 about like fussing, making sure that the breaks were 11:39
16 allocated before, you know. Whereas I would have been
17 very much about 'well, let's get everything sorted and
18 then we'll look at the breaks or look at the staffing
19 situation', whereas there was a couple of older ladies
20 that I would have worked with would have been running 11:39
21 around with the allocation sheets going 'Oh, everybody'
22 -- and like everybody did get their breaks, they might
23 not have just been like 10:00 o'clock, 10:30, they
24 might have been getting it at 11:00 or just slightly
25 after, and like people might have been panicking, just 11:39
26 because the wards could be tense just.

27 120 Q. Just on the allocation sheets, since you mentioned it,
28 and I was going to come to it.
29 A. Okay.

1 121 Q. what is the allocation sheet?
2 A. Allocation sheet would have been, so for talk's sake,
3 it would have been done on daily basis and the
4 allocation sheet was to allocate tasks to staff. so
5 that would have included the nurse in charge, the 11:39
6 back-up nurse, and the people that were going to be
7 allocated to the groups. So the patients would have
8 been grouped into Group 1, 2, 3, and 4, for talk's
9 sake, and then the levels, which would have been people
10 that would have required the one-to-one Level 3, so 11:40
11 that would have been all. So you could have went in
12 and looked and it would have been in the office. So at
13 the start of the shift...
14 122 Q. Just slow down just a wee bit.
15 A. Oh, sorry. 11:40
16 123 Q. You're okay.
17 A. So at the start of the shift people would have come in
18 and looked at the sheet, and then they would have known
19 where they were allocated. So I would have looked at
20 that and says 'Right, well I'm allocated to so and so', 11:40
21 or whatever group, 7:25 to 9:00 o'clock, knowing that
22 they were going to the day care, or a Level 3, 7:25 to
23 13:00 hours, or you could have been the nurse in charge
24 and then you would have known then that you were taking
25 charge of the wards, you were doing the medicines, you 11:40
26 had to phone over to the nursing office if you needed
27 staff, you had to contact the doctor, you looked in the
28 diary, you know. But that would have been all
29 allocated so that at any one time anybody could have

1 just looked at that and said 'Right, well I'm looking
2 for so and so. They are on Group 2, so they should be
3 down where Group 2 are', or they're allocated to Level
4 3 so and so, they will be down in that room. So it
5 was... 11:40

6 124 Q. And were allocation sheets hospital wide?
7 A. Yeah, like all the wards would have had them, yeah.

8 125 Q. Okay.
9 DR. MAXWELL: Can you explain what a back-up nurse is?
10 You just said -- 11:41

11 A. I suppose we would have been very lucky to have back-up
12 nurse.
13 DR. MAXWELL: But I don't know what it means.

14 A. Yeah. No, a back-up -- it was just literally a second
15 registered nurse that was on the shift. 11:41

16 DR. MAXWELL: So there sometimes only be two registered
17 nurses on duty?
18 A. Mhm-mhm.

19 DR. MAXWELL: And from what you're saying sometimes
20 only one. 11:41

21 A. Yeah. Yeah. So in Greenan we would have had two
22 medicine trollies, and one of the times it took I think
23 about three and a half hours to do the medicine round,
24 so then we split it into two medicine -- like split it
25 properly into two medicine trollies so that the nurse 11:41
26 in charge would have done one and the back-up nurse
27 would have done it.
28 DR. MAXWELL: But it would have been -- it wouldn't
29 have been unusual only to have one registered nurse on

1 the shift?

2 A. It didn't happen very often, but it had happened, yeah.

3 DR. MAXWELL: But you told us earlier that there were

4 groups of registered nurses sitting in the office.

5 A. Well, that was M4. Sorry, I'm speaking about -- I'm 11:42

6 just sort of referencing Greenan.

7 DR. MAXWELL: So in Greenan there was a lower number of

8 registered nurses because this was a ward for people

9 who were stable and waiting for community placements?

10 A. Ehm, yes, and I suppose -- I think as well not a lot of 11:42

11 people wanted to work in Greenan because it was deemed

12 to be a heavy ward, you know, there was a lot of --

13 DR. MAXWELL: Physically heavy.

14 A. Physically heavy, yeah. And I think, you know, at the

15 start of the statement when I was offered to go there 11:42

16 rather than Donegore, they were shocked that I had said

17 I would rather go there and stay there if I could, just

18 because I had experience of there.

19 DR. MAXWELL: So it was harder to recruit to Greenan

20 than it was to M4? 11:42

21 A. I think so. Well, just I think if people had of been

22 given the option they would have rathered not worked in

23 Greenan.

24 DR. MAXWELL: Thank you.

25 126 Q. MR. McEVOY: In 23 you say that you always felt 11:42

26 supported in your role at Muckamore. H154 was very

27 supportive, you say.

28 A. Mhm-mhm.

29 127 Q. And you give an example. When you were getting married

1 she made sure you were made exempt from relief duty.
2 A. Mhm-mhm.
3 128 Q. where staff members would have to go to other wards
4 which were short staffed, and you explain that the
5 reason why she made sure you were exempt was so that 11:43
6 you didn't get injured before your wedding.
7 A. Yeah.
8 129 Q. On the run up to your wedding there were significant
9 injuries to many staff in the ICU, including serious
10 facial injuries. 11:43
11 A. Mhm-mhm.
12 130 Q. Can you give -- thinking back, can you give a reason
13 why there might have been so many injuries to staff in
14 that period? And I suppose there's a second part to
15 that same question. 11:43
16 A. Okay.
17 131 Q. The fact that so many assaults were happening, did that
18 affect staff behaviour towards patients, staff
19 interactions with patients?
20 A. The particular patient that was causing these injuries 11:43
21 had been moved. I'm not sure what I can say. Can I
22 just...
23 132 Q. well, don't name the patient, but I think you can --
24 A. No. So he had been -- this patient had been moved from
25 the children's services up. I think now slightly, I 11:44
26 think from memory slightly before his 18th birthday,
27 because he was so challenging. Subsequently has I
28 think gone to be nursed in England, which has -- he
29 required like a higher security, sort of like a high

1 secure.

2 DR. MAXWELL: So it was known before he came to MAH
3 that this patient had particular difficulties and
4 challenges. Did the Trust ensure that there were
5 additional staff? 11:44

6 A. To be honest, I don't know. It wasn't my ward. But I
7 know, because I know people, that staff would have been
8 sent from the children's up with him because they were
9 familiar with him.

10 DR. MAXWELL: Okay. But that may not have meant there 11:44
11 were enough staff. They were moving him because they
12 couldn't manage him there?

13 A. Yes, I think he had caused a serious injury to another
14 child.

15 DR. MAXWELL: Yes. No, my question is not about his 11:45
16 behaviours, it's about the response of management to
17 that. Did they recognise this was a high risk patient
18 and, therefore, needed maybe a different skill set, or
19 more staff, or both.

20 A. No, I think it was maybe a week before his 18th 11:45
21 birthday, and I think naturally they felt that he was
22 going to be nursed in ICU.

23 DR. MAXWELL: I understand that. But when he got to
24 Muckamore was there a recognition that he was a higher
25 risk patient than some others, and probably needed more 11:45
26 and different staff support?

27 A. I don't know. I wouldn't have -- I was only ever in
28 ICU as a relief staff.

29 DR. MAXWELL: So you weren't working in ITU, but

1 nevertheless it was decided that because of your
2 wedding you should avoid injuries, particularly facial
3 injuries. Does this mean that there were patients on
4 your ward who were injuring staff?
5 A. Well on Greenan, the ward I worked in, people would 11:45
6 have been getting their thumbs -- there was a couple of
7 thumbs broken, but that would have been like sort of
8 the most extreme injury.
9 DR. MAXWELL: So why was there a need to make sure you
10 weren't injured before your wedding? 11:46
11 A. Because the -- I think on the couple of weeks before my
12 wedding there was a female member of staff had her nose
13 broke, another had her cheek bone --
14 DR. MAXWELL: On your ward?
15 A. No, no, no, in ICU. So it was to prevent me from going 11:46
16 to any other ward. So I wasn't being sent out on
17 relief because the injuries were so significant.
18 DR. MAXWELL: Okay. Thank you.
19 133 Q. MR. McEVOY: Okay. You then go on, well you confirm
20 then that at paragraph 25 you weren't involved with the 11:46
21 admission of patients to the hospital. The wards you
22 worked on had long-term patients.
23
24 Then in 26 you say that you don't recall ever having
25 had any issues with family members visiting the wards. 11:46
26 Greenan was an open door ward and families could come
27 and visit when they wanted because they would have the
28 code. M4 was locked, but families would just ring the
29 bell and they would be shown to the visitors room.

1
2 "It would not have been appropriate in some of the
3 wards for family visitors to go in to the main day
4 areas as it would potentially have been a risk to
5 them." 11:47
6
7 That's Moylena you're talking about there?
8 A. Yeah. Yeah.
9 134 Q. Yeah:
10 11:47
11 "Sometimes family would ring ahead to let us know they
12 were calling up and if they were taking the patient out
13 or not."
14
15 There were minor issues around clothing, you say, but 11:47
16 never anything serious. What type of minor issues do
17 you mean?
18 A. Like stuff would have went over to the laundry and then
19 maybe would have taken a couple of weeks to come back,
20 or it would have been sent to another ward, so then it 11:47
21 sort of would have went round the hospital by the time
22 it came back. It was mostly if you had knowledge of
23 the hospital you would have known what ward to send the
24 clothes back to. Or socks were always a difficult!
25 135 Q. Yes. We've had evidence in the Inquiry from relatives. 11:47
26 A. Yeah.
27 136 Q. Who described the stress about clothing items going
28 walkabout within the hospital, and things going
29 missing, and spending money, quite a lot of money in

1 some instances, buying nice items of clothing for their
2 family members and then those things going missing. Do
3 you recall family members being distressed about that?

4 A. Not in my wards.

5 137 Q. Yes. 11:48

6 A. So as I was saying earlier on about being the named
7 nurse, we would have had to have an inventory of all
8 the items of clothing that each patient had and that
9 would have been like randomly checked.

10 138 Q. Yes. 11:48

11 A. So like the ward Manager, or she could have sent you to
12 go and check to make sure that so and so, all the items
13 are there, and like we would have kept an inventory on
14 the ward of the people's belongings. Not sure why that
15 might not have been the case on other wards. 11:48

16 139 Q. Yeah.

17 A. But we didn't really have anything other than like
18 socks going missing, or maybe not the pairs. Like that
19 was -- do you know, we didn't have anything.

20 140 Q. Yeah. 11:48

21 PROFESSOR MURPHY: Was there still a centralised
22 laundry?

23 A. So for the rest of the hospital -- we would have used
24 the centralised laundry, but the like of Cranfield,
25 Cranfield would have had a like a laundry service on 11:49
26 site. So from memory --

27 PROFESSOR MURPHY: Because it was a newly built ward?

28 A. Yeah. Yeah, yeah, yeah. And I suppose that was with
29 the view that all the other buildings were going to be

1 obsolete and then they were going to be self-sufficient
2 and have their own laundry. But we, in Greenan and M4
3 would have used the centralised. So it would have been
4 taken away. You would have left the bags out in the,
5 we had like a big shed out the side of the ward, and we 11:49
6 would have left the bags there and they would have been
7 collected and then the laundry would have been
8 delivered back to the ward.
9 PROFESSOR MURPHY: So your laundry was in a bag
10 labelled with the name of the ward? 11:49
11 A. Yeah.
12 PROFESSOR MURPHY: Was it so that that was the only way
13 they could prevent --
14 A. Well, in the long stay wards all the patients had their
15 item of clothing personalised with their names. So say 11:49
16 for talk's sake I bought 10 new items for a patient, I
17 would have got the marking book, we had a marking book,
18 and would have written 'pink jumper, blue jumper',
19 blah-blah-blah, for whoever, and then sent that over
20 for marking. So like the industrial labels, you know, 11:50
21 they would have been hard washing, you know, they
22 wouldn't have come off. And that's how -- like so that
23 would have went in the bag for Greenan, and then when
24 they came back, all the stuff, and that would have been
25 a ward duty then to sort out the clothes and then put 11:50
26 them all in people's wardrobes or drawers.
27 CHAIRPERSON: So there was a system on some wards for
28 tagging the clothes?
29 A. Yes.

1 CHAIRPERSON: Physically putting a tag on each article
2 of clothing?

3 A. Yes. So we would have sent it out to the laundry with
4 the marking book, and that was -- so the purpose of the
5 marking book was to get the labels put on it. However, 11:50
6 I know that the feeling was that was very
7 institutionalised, and I know -- it's very
8 institutionalised. However, that eradicates the risk
9 of losing clothes, you know. It's a kind of Catch 22.
10 But I know like in the newer wards, I remember being on 11:50
11 relief in Cranfield Men and a particular male patient,
12 a family member was going to do his laundry, and he had
13 soiled himself, and I ended up having to put on like
14 Bermuda like swimming shorts on him, because that was
15 the only items of clean clothing that he had. It was 11:51
16 -- I had to go back to the staff and went "I'm really
17 sorry, but that's all that he has in his drawers", so
18 they had said that they were going to contact the
19 family to say that he needs -- I think the family, or
20 the mummy or somebody would have come up and visited 11:51
21 him a couple of times a week, would have taken the
22 clothes home. But I think on the newer wards they were
23 trying to move away from that.

24 CHAIRPERSON: Right. So on some wards there was
25 tagging? 11:51

26 A. Yeah.

27 CHAIRPERSON: On others there wasn't. Did it depend on
28 whether the clothing was going to go to the central
29 laundry or not?

1 A. I don't think so. I think -- now, I'm not sure, I
2 might just be making -- I'm not sure if this is
3 accurate or not, but I think the idea was that the like
4 of Cranfield -- so initially Cranfield women's,
5 Cranfield Men, and ICU, that was the three wards, there 11:51
6 was a lot less patients, and because they were sort of
7 newly or newer admitted they wouldn't have had the
8 level of clothes that the other ones in the other wards
9 would have had, so I think the method behind it would
10 have been, or the thought behind it, sorry, would have 11:52
11 been that 'well, there's six patients there, six
12 patients,there, six patients there', I as a staff
13 member this ward knows each others --
14 CHAIRPERSON: And you've got an inventory.
15 A. Yeah. And I think that might have been what they were 11:52
16 gearing for. But we were a lot stricter with the
17 inventory in that, you know, I suppose we were maybe
18 old style sort of still doing the institutionalised
19 stuff, but it worked because we had so many clothes.
20 CHAIRPERSON: Thank you. 11:52
21 141 Q. MR. McEVOY: Okay. At the top of page 11 then at
22 paragraph 27, you talk about how, when you went to a
23 new ward, you were given a verbal run down on the
24 patients and their individual skills and the medical
25 file of each patient was made available to staff 11:52
26 members. Care plans were recorded in the nursing
27 notes. When you first started in Muckamore you were
28 given time to read each patient's nursing notes. Did
29 that change?

1 A. No, I think I was asked just were you, and I says 'yes,
2 I was'.
3 142 Q. Okay.
4 A. But like I know if I was doing an induction to
5 somebody, or even somebody was over on relief, that's 11:53
6 where like the verbal run down would come from. But if
7 it was a new staff member, you would be sat down and go
8 through it very like thoroughly of each patient.
9 143 Q. Okay. Before the PARIS system was introduced these
10 notes were all handwritten, and included in each 11:53
11 patient's nursing file were the assessment, activity
12 and care plans, and that was known as the Kalamazoo.
13 Am I saying that correctly?
14 A. Yeah.
15 144 Q. 11:53
16 "The Kalamazoo consisted of paper notes of
17 approximately 10 to 15 sheets of paper for each patient
18 and that was an easy way to get caught up with all the
19 recent information. Each patient also had a medical
20 file and these were used for the MDT meetings. The 11:53
21 files were kept in two cabinets in the office. The
22 doctor would have been aware of any significant changes
23 to a patient's care plan and would have recorded dates
24 in the doctor's diaries if, for example, anything was
25 to be reviewed, such as a patient meeting, a Kardex 11:54
26 rewritten or a prescription of medication by the
27 out-of-hours GP, and would also have included any
28 changes in speech and language guidance or occupational
29 therapy assessment."

1 A. Mhm-mhm.

2 145 Q. Is it -- would the Inquiry be correct in understanding
3 that MDT notes were separate from nursing notes?

4 A. Yes and no. I suppose any of the assessments, so the
5 like of OT coming onto the ward, they would have had 11:54
6 their own folder, but -- like if they of had an
7 assessment, like a copy that of assessment would be
8 carried in the nursing file, and then there would have
9 been like notes I would have written saying "so and so
10 occupational therapist came and visited. See updated 11:54
11 assessment", or whatever.

12 146 Q. So the nursing notes would have directed you to the MDT
13 notes?

14 A. Yeah, yeah, to the new updated. Speech and language
15 could have been updated. But mostly people, anybody 11:55
16 writing in the medical notes would have been the
17 doctor, would have been writing in their own.

18 147 Q. And would you expect then that you would have been able
19 to see that, see MDT input, regardless of whether there
20 were staffing issues or anything else that might have 11:55
21 been getting in the way?

22 A. Yeah. Well, we would have contacted -- if you needed
23 somebody, you know, for talk's sake, if we had somebody
24 and an example of you thought they maybe were holding
25 food in their mouth or they weren't eating. 11:55

26 148 Q. Yes.

27 A. Like we would have immediately contacted the speech and
28 language, you know, and they would have been over for
29 the next meal time. You know you could have phoned

1 them at 9:00 o'clock and said -- or you could have
2 phoned them and said 'night duty staff last night felt
3 that she seemed to be not eating well or struggling
4 with the large', you know, or whatever it could have
5 been, and we would have contacted speech and language, 11:55
6 and we would have had a good lot of input from the
7 occupational therapists, because at that time they were
8 moving to more like personalised, like really sort of
9 higher tech, higher spec chairs for the people, that
10 they could. So we would have had people would have had 11:56
11 wheelchairs and like soft seats to sit in, but that was
12 kind of around the time that there was -- I don't know,
13 from the OT point of view like it was a new, finding
14 that these chairs could be actually sat in all day and
15 it was a wheelchair. So we would have had a good bit 11:56
16 of input from the OT, but they would have been on the
17 ward quite often. But anybody, if you had of needed
18 them, you would have phoned them and says 'you need to
19 come for so and so', or whatever. Like there would
20 have, there would have been a lot of input. 11:56

21 PROFESSOR MURPHY: But the fact remains, from what
22 you're saying, that there were nursing notes, there
23 were medical notes that the doctors wrote in, there
24 were SALT notes, there were OT notes, there were
25 psychology notes, and maybe even behavioural notes, all 11:56
26 separate.

27 A. Yeah. Yeah. But on the ward what would have been kept
28 would have been the nursing folder. So the nursing
29 file for the person and the medical notes. So the like

1 of psychology would have kept their folder. We would
2 have had a copy of it included in the nursing notes,
3 but they would have had, like on their, in their own
4 office or whatever their filing system was, they would
5 have had their own notes. And the like of OT, they 11:57
6 would have had their own folder for the person and kept
7 wherever they were.

8 PROFESSOR MURPHY: And is that still the case?

9 A. In the hospital?

10 PROFESSOR MURPHY: Yes. 11:57

11 A. I'm not sure. I don't know. I suppose that was the
12 benefit then of PARIS coming in that everything was
13 centralised, that everybody then could see -- but I
14 suppose that was old-fashioned, that everybody had
15 their own thing, and that was the purpose of PARIS. 11:57
16 But I would imagine -- well, I know from community that
17 it is all sort of centralised on PARIS and I can go and
18 look, I can do a referral to OT and then I can go and
19 see that the OT has been out and what they've done and
20 what they've recommended. So it is all centralised 11:57
21 now.

22 PROFESSOR MURPHY: Thank you.

23 CHAIRPERSON: When did PARIS come in? I know we've
24 been told this, but I can't remember.

25 A. Maybe 2014 or 2015. 11:57

26 CHAIRPERSON: Right. Around then. Okay.

27 149 Q. MR. McEVROY: Okay. Then you go on to talk about your
28 experiences with the patient sort of on a general
29 level. The more you got to know a patient the more you

1 understood about them, behaviours, changes in mood.
2 Some patients would decline around the anniversary of
3 the death of a loved one. One patient you recall who
4 would get excited on a Friday as their mum would come
5 and visit on Saturday. Others might present as having 11:58
6 symptoms of dementia, but it might have been a symptom
7 of something else, for example, UTI. In Greenan, and
8 I think you told us about this:

9
10 "In Greenan the ward patients did not tend to have 11:58
11 challenging behaviours, but there were occasions when
12 staff on Greenan had their thumbs broken by a
13 particular patient. M4 Moylena was slightly more
14 challenging."

15 11:58
16 You were trained in MAPA as a Band 5 nurse.

17
18 "On M4 you didn't use MAPA, but it was required on the
19 ward."

20 11:58
21 In other words, used by others and not you.

22 A. Mhm-mhm.

23 150 Q.

24 "In Greenan the PRN medication that would have been
25 administered would mostly have been paracetamol and 11:58
26 either a 1g or half a milligram of Lorazepam. This was
27 one patient in particular and would have requested this
28 herself if she felt she needed it."

1 was that the case with most PRNs, that patients, and
2 I'm thinking about Greenan here...

3 A. No. So in Greenan a lot of them wouldn't have had --
4 see like that Lorazepam, from memory it's -- I'm just
5 thinking of one person in particular, and she says like 11:59
6 'will you give me a wee point 5 there'.

7 151 Q. Right.

8 A. Because she was feeling a wee bit stressed.

9 152 Q. Yeah.

10 A. And she would have requested it, and you know she 11:59
11 wouldn't have --

12 153 Q. She knew?

13 A. Yeah, she knew. She would have been the one that was
14 breaking the thumbs.

15 154 Q. Right. 11:59

16 A. So she would have come back and been very remorseful
17 and says 'Oh, like if you give me that I'll be all
18 right now', sort of thing.

19 155 Q. Yes.

20 A. But she would have been the only person, other than 11:59
21 somebody, like anybody else it was Paracetamol, do you
22 know, and you would have done that, do you know, if you
23 felt they were displaying that they may well have had a
24 headache or a temperature or anything. It was just
25 about knowing the patient. But she would have been the 12:00
26 only person that would have verbally asked for
27 anything.

28 156 Q. But PRN was more of a feature then on Moylena?

29 A. M4, yeah.

1 157 Q. Yeah.

2 A. Yeah. Yeah.

3 158 Q. Higher doses were given, but you can't recall more
4 specific details?

5 A. No, I can't. I just remember just looking at it, going 12:00
6 'this is very different', it was very different
7 clientele.

8 159 Q. Right. Yeah. Okay. I'm just at the top of page 12
9 now:
10
11 "As Staff Nurses we would have been there to review the
12 use of medication and discussed it with doctors about
13 reducing it if the patients didn't need it. When PRN
14 was prescribed to the patients it was always a clinical
15 decision led by the doctors following discussion with 12:00
16 MDT. If a patient required PRN it would have been
17 recorded on the patient's Kardex by the relevant Staff
18 Nurse and talked through at the handover at the end of
19 the shift as well. We would have monitored the
20 behaviours of patients as they happened and then would 12:00
21 monitor and record why they happened, if we knew the
22 reason. For example, if there were any contributing
23 factors such as the noise level on the ward that might
24 have caused the patient to request the medication."
25
26 was that the practice? In other words, was that done
27 all the time? It was something that was done -- in
28 other words you would have sought to put a reason down?
29 A. Yeah. Well I suppose for anything behaviour wise, you

1 know.

2 160 Q. Yeah.

3 A. Like you were always sort of thinking, like we would

4 talk about the ABC, what's the antecedent, you know,

5 there was always a cause. 12:01

6 161 Q. Yes.

7 A. So it wasn't just somebody decided to do whatever, you

8 know, we would always look and see 'Right. well

9 actually it was because so and so and so and so was

10 there.' 12:01

11 162 Q. Yes.

12 A. Or if the OT had been in, you know, and they had been

13 irritated by a high like sort of footfall on the ward.

14 163 Q. Yes. So you would expect to see a reason for the PRN.

15 There was never -- you don't recall ever seeing gaps? 12:01

16 In other words, no reasons.

17 A. From experience, no. No, it would have been -- you

18 would have had to explain why you were...

19 164 Q. Okay. Thank you. Then at paragraph 30 you talk about

20 the nursing assessments carried out annually or when 12:01

21 required in both Greenan and Moylena. If there was a

22 physical deterioration and it was clear, that would

23 cause an assessment. You talked earlier on in your

24 evidence about noticing physical deterioration,

25 especially maybe when resettlement came on to the 12:02

26 equation.

27 A. Yeah.

28 165 Q. would an assessment have been done at that stage?

29 would there have been a need for a reassessment if you

1 had noticed --

2 A. Oh, if there was any change whatsoever. So the

3 assessments would have been -- the reassessment would

4 have been done yearly, but if there was any sort of

5 change whatsoever, that would have triggered 12:02

6 reassessment.

7 166 Q. Okay. And then a little bit on down in paragraph 30

8 you talk about audits on Greenan and Moylena carried

9 out by the ward managers. Can you tell us just what

10 the audits involved, in broad terms? 12:02

11 A. I suppose from memory, I remember in Greenan there

12 being an audit to make sure that the care plans were up

13 to date. I remember there being a financial audit to

14 make sure, like because you were dealing with quite a

15 lot of money. 12:02

16 167 Q. Yes.

17 A. So we were making sure that -- we would have had -- we

18 had folders for everything, but we would have had a

19 folder for like the paper, but there were like you know

20 the carbon copy, there would have been three. One went 12:03

21 to the cash office, one went I think on the file, and

22 one went -- I can't remember actually on our thing, but

23 we would have had the pink form, I think, and would

24 have stapled the receipts for the purchases. So I

25 would have requested £200 for clothes and then I would 12:03

26 have had to make sure then that the receipt tallied up.

27 So like there would have been a lot of financial

28 audits. I remember being on the ward when pharmacy

29 were doing an audit to make sure, you know, we had

1 Oramorph on the ward. So that sort of...

2 168 Q. That's a strong --

3 A. Yeah, it's liquid morphine.

4 169 Q. Yes.

5 A. So it was for oral morphine, sorry. Or for a PEG, 12:03

6 sorry. But like we would have had medication audits as

7 well. I can't remember how often, but the head

8 pharmacist would have come out and he would have looked

9 at the controlled drugs book, and that would have

10 incorporated then looking to see where the controlled 12:03

11 drug key was kept, you know. So one of the times then

12 we didn't have controlled drugs on the ward, so then

13 our controlled drug key would have had to be kept in

14 the nursing office, because it wasn't appropriate for

15 it to be kept on the ward, which we all learned when 12:04

16 the pharmacist came out! But other than that, if there

17 was controlled drugs, the nurse in charge had to have

18 the controlled drug key.

19 DR. MAXWELL: Can I ask about the care plan audits? So

20 was that using a particular audit tool? Was there a 12:04

21 written document?

22 A. Well, I'm not sure what she would have been doing, but

23 from memory then it would have been mentioned in the

24 notes, from memory, like "care plan reviewed today" and

25 whatever discontinued, you know, on the nursing notes. 12:04

26 But in the care plan itself it would have been making

27 sure things -- some of the stuff you would have seen in

28 the care plans would have been maybe from like years

29 before like and somebody has physically deteriorated,

that they wouldn't be -- that wouldn't be a risk anymore, so it wouldn't have necessarily needed to be in --

DR. MAXWELL: So this was a review of an individual patient's record?

12:05

A. Yeah, yeah, yeah.

DR. MAXWELL: Rather than an audit of all the records on the ward at a point in time, to make sure that they got all the entries, all the risk assessments done?

A. No, I think it was sort of more like --

12:05

DR. MAXWELL: As a review.

A. Yeah, more of a review, when she would have been auditing to make sure that they were up-to-date.

170 Q. MR. McEVROY: okay. At 31 then:

"For both Greenan and M4 treatment plans were not used as the patients were long stay patients and were not receiving treatment."

I suppose, the person out on the street, or a member of the public following the Inquiry might say 'well, if they were long stay patients and weren't receiving treatment, why were they in hospital?'. Can you help us with that?

A. Yeah. Well that's why then with government papers of the resettlement and the closure of the long stay hospitals, I suppose in the 50s and 60s a lot of these people would have been admitted to Muckamore over the years, with the downsizing and the sort of introduction

1 of more community placements. I think it was to do
2 with funding why there was a lot of people held up not
3 getting out to the community earlier.

4 171 Q. Yes.

5 A. I suppose they were being looked after and receiving 12:06
6 nursing care, but that could have been met in a nursing
7 home.

8 172 Q. Yeah.

9 A. But it was just at that -- well when they were
10 admitted, that was the sort of standard procedure, that 12:06
11 people would have been admitted to long stay hospital
12 if their family couldn't provide the care that the
13 person required, or sometimes people just were sort of
14 advised to bring their loved one to a long stay
15 hospital where they would have been getting at a time 12:06
16 treatment, or what was deemed to be treatment in the
17 care place.

18 DR. MAXWELL: Can I ask what's the difference between a
19 treatment plan and a care plan?

20 A. Yeah. They asked about like with the new -- I think it 12:06
21 was in relation to like the newer...

22 DR. MAXWELL: The what, sorry?

23 A. The newer people that had been admitted, or they're
24 supposed to be -- from what I know was they were like
25 under a treatment plan of like 'Right. well you're 12:07
26 here for six weeks' assessment', and then if they were
27 going to review that, like that sort of treatment plan.

28 DR. MAXWELL: So is a treatment plan a separate
29 document from a care plan?

1 A. Not that I know of. I don't think so. I think that's
2 just been worded not...
3 DR. MAXWELL: I'm struggling to understand.
4 CHAIRPERSON: So was there a question of timing? Did a
5 care plan become a treatment plan. 12:07
6 A. No, they asked me were they under any treatment plans?
7 I think it has just been a misunderstanding with
8 whoever --
9 DR. MAXWELL: Oh, the Inquiry asked?
10 A. Yeah, yeah, they asked me, and I said that -- 12:07
11 DR. MAXWELL: So we need to --
12 A. -- they weren't under any treatment plan.
13 DR. MAXWELL: -- wonder what we thought it meant.
14 A. I felt what they meant was like the newer wards or the
15 newer admitted people were there for -- they obviously 12:07
16 weren't going to be there for 40 years. So what I
17 think that they were meaning was like, so for somebody
18 being admitted they're likely going to say 'Right,
19 you're going to be assessed for six weeks and receive
20 treatment for six weeks', and that's part of their 12:07
21 treatment plan.
22 DR. MAXWELL: So everybody had a care plan?
23 A. Yeah.
24 DR. MAXWELL: Regardless of whether they were actively
25 on some programme or not? 12:08
26 A. Yeah. Yeah.
27 DR. MAXWELL: And the decision about what sort of
28 interventions they would receive would be discussed at
29 the MDT meeting?

1 A. Yeah, I suppose. Yeah. I suppose with the longer stay
2 patients, the ones that I worked with, it was
3 well-established that they were just there to be
4 nursed.

5 DR. MAXWELL: But was there an MDT meeting -- 12:08

6 A. Yeah, we would have them.

7 DR. MAXWELL: -- for the longer stay patients.

8 A. Yeah, we would have had them.

9 DR. MAXWELL: So had their condition changed and they
10 might have benefitted from, for example, DBT, that 12:08
11 could have been discussed at the MDT and it could have
12 been implemented?

13 A. Well I suppose they could have been. But at that time
14 DBT wasn't being offered to the like of the patients.
15 Initially, I think from memory, it was being offered to 12:08
16 the forensic patients when I worked in Muckamore, and
17 I'm not sure that they would have deemed the cognitive
18 levels of the patients that I worked with on that ward,
19 that they would have either benefitted or been able to
20 fully participate in it. But, no, there definitely was 12:09
21 -- there was the MDT meetings, and there was
22 discussions, and a lot of the MDTs were held with the
23 community like care manager to be included, so that we
24 were continually trying to plan.

25 DR. MAXWELL: So all patients had a care plan, but most 12:09
26 of the patients on Greenan and M4 were not receiving
27 what you would consider to be an active treatment for
28 their condition?

29 A. No, they were just being nursed and looked after in the

1 hospital.

2 DR. MAXWELL: Okay. Thank you.

3 173 Q. MR. McEVOY: Towards the end of -- the final sentence,
4 in fact, at paragraph 31, bottom of page 12, you talk
5 about how there were certain therapies used, DBT and 12:09
6 CBT and so on, and in this final sentence you say that:
7
8 "In M4 and Greenan the patients on those wards were not
9 undergoing any form of treatment or taking part in
10 therapies, other than music therapy or the 12:09
11 aromatherapist on sight."
12
13 Is that -- there's no therapeutic input of any
14 description then?

15 A. I suppose that probably reads, you know, quite 12:10
16 negatively, but I think what they were asking was like
17 the like of people maybe on the Forensic ward that
18 would be undergoing a treatment plan to sort of lessen
19 the likelihood of them re-offending.

20 174 Q. Yes. 12:10

21 A. Or somebody who has been admitted, that, 'Right. Well
22 we're going to provide care, assessment here, adjust
23 medication in the hope that when you are discharged
24 that you can live in the community and don't require
25 readmission', and I suppose that looks negatively that 12:10
26 nothing was being offered to these people. But, you
27 know, they were -- do you know, they were there.

28 175 Q. Yes.

29 A. They had been there for 40/50 years. They were being

1 looked after, they were being nursed, they were
2 attending their day care, you know. If we felt that,
3 you know, we would have had music people coming in
4 weekly, and we would have had -- like they would have
5 had the music therapists coming in weekly, and they 12:10
6 would have had people, like we would have paid -- like
7 the ward would have paid for like bands, like people to
8 come in.

9 176 Q. Yes.

10 A. And there was the aromatherapist. But I think that 12:10
11 just probably looks badly that they're not receiving,
12 but they are, they're being really well looked after.

13 177 Q. Yeah. It's just that when you read that sentence and
14 then the sentence at the top of the next page, page 13,
15 the very next sentence says: 12:11
16

17 "These patients would have been involved in extreme
18 incidents."
19

20 A. Yeah. 12:11

21 178 Q. And I suppose when you read that --

22 A. That was actually in reference -- I had picked up on
23 that the other day. That's actually in reference to
24 the -- in the paragraph about the Oldstone Bungalows.

25 179 Q. Right. 12:11

26 A. So they -- I'm not sure the flow of that.

27 180 Q. Okay.

28 A. But that was do with patients that were in Oldstone
29 that were forensic. So that's what that's actually in

1 relation to, because I looked at that --

2 181 Q. So the sentence is out of sequence then?

3 A. Yeah, that is. Yeah. Because when I seen that, I was

4 like "oh". No.

5 182 Q. Because when one reads those two together -- 12:11

6 A. Yeah. No, no, that's -- because that's in relation to

7 the Oldstone Bungalow patients that were of a forensic

8 nature. So that's I think...

9 CHAIRPERSON: So "these patients" doesn't actually

10 refer to paragraph 31? 12:11

11 A. No. No, no. It refers --

12 MR. McEVOY: It refers to the earlier reference about

13 the Oldstone Bungalows.

14 A. Yes.

15 183 Q. When you went -- and that's when you went over, I think 12:12

16 in your evidence, you went over and you were looking

17 after patients on your own, and we talked about that?

18 A. Yeah. I can't actually see what paragraph it's in.

19 184 Q. Paragraph 13.

20 A. 13. Yeah. Oh, sorry. Yeah. 12:12

21 185 Q. Towards the end that of paragraph --

22 A. So that's actually in relation to that there, with the

23 forensic patients.

24 186 Q. Okay.

25 A. Because that was -- because I remember that when I was 12:12

26 reading that I was asked about how those people ended

27 up being in the hospital, and I had said that they were

28 of an extreme forensic nature.

29 187 Q. So 32 should follow?

1 A. 13.
2 188 Q. 13?
3 A. Yeah.
4 189 Q. The whole of that paragraph?
5 A. Mhm-mhm. 12:12
6 CHAIRPERSON: Thank you.
7 MR. McEVOY: Okay. So we can take up maybe then at 33:
8
9 "The patients I worked with in Greenan and M4 would
10 sometimes self-harm." 12:13
11
12 A. Mhm-mhm.
13 190 Q. And you describe one of the patients that you work with
14 who had caused paralysis to her lower body and would
15 pick her skin on the legs which would require them to 12:13
16 be dressed. Never got the chance to heal. You'd have
17 had to ensure nails were cleaned a few times daily.
18 Some patients were autistic and had ritualistic
19 behaviours. You remember getting hit several times in
20 the face, and head, and shoulders, while doing the 12:13
21 medication round because a patient didn't get his
22 desired yoghurt. You locked the trolley and brought
23 him to yoghurts to show him the flavours for him to
24 chose one. Was that a typical behaviour?
25 A. Yeah, that like - yeah. 12:13
26 191 Q. On those wards?
27 A. Yeah. Yeah.
28 192 Q.
29 "If the ward became very noisy some patients at times

1 couldn't manage this. One of the key things was to
2 keep certain patients separate on the wards and this
3 would have been recorded on each care plan. For
4 example, the care plan would indicate if a patient did
5 not get on well with another patient or if a patient
6 preferred a quieter day room. I recall there was a
7 patient who would defecate on the floor and smear it
8 due to a sensory need."

12:13

9
10 Then you say:

12:14

11
12 "The ward staff started to give the patient cream and
13 allowed her to smear the cream on the floor as she
14 liked the feeling and sensation of it and reduced the
15 instances then of the defecating behaviour."

12:14

16
17 A. Mhm-mhm.

18 193 Q. In terms of what you tell us about keeping some
19 patients apart, and the impact of noise on the number
20 of incidents that happened, was there a discussion
21 among ward staff about the possibility of reducing the
22 patient numbers on the ward, like having smaller groups
23 of patients?

12:14

24 A. That would have probably required them to be resettled
25 or discharged.

12:14

26 194 Q. Yeah.

27 A. I think at the time it was the best that we could do.
28 You know historically they would have known that so and
29 so didn't get on with the other one, and like they

1 wouldn't -- or there may have been incidents in the
2 past and staff would have ensured that they were in
3 different day spaces. But I suppose ideally, yes,
4 reduce. But there was nowhere to move them to.
5 PROFESSOR MURPHY: But given that wards were closing. 12:15
6 A. Pardon?
7 PROFESSOR MURPHY: Given that wards were closing.
8 Surely one of the decisions that could have been made
9 was to have smaller groups of patients?
10 A. Yeah. Yeah. 12:15
11 PROFESSOR MURPHY: It didn't necessarily mean they had
12 to be out in the community, although obviously that was
13 the long-term aim. But short-term could not the wards
14 that had been emptied have been used for reducing
15 patient numbers? 12:15
16 A. There was a lot of empty buildings. Yeah. I think
17 that would probably come down to the staffing then,
18 that if they were to create another ward, or reopen
19 another ward, that they would have to staff it, and I
20 would imagine that that wasn't really in the greater 12:15
21 plan.
22 PROFESSOR MURPHY: Do you think that was a financial
23 decision really?
24 A. I think it was a person issue. They wouldn't have had
25 -- I don't think that they would have had the staff or 12:15
26 the people to staff it safely. It was probably
27 resources. It was probably a number of factors. I
28 probably think that they probably didn't want to be
29 seeming to be opening another ward, or reopening

1 another ward, because that would have had a negative
2 look on the hospital, that you were supposed to be
3 downsizing and resettling people, but here we are
4 reopening a previously closed down ward. It would have
5 been deemed that, you know -- we had a lot of negative 12:16
6 press that you were trying to keep people there or
7 you were against resettling, and I suppose if they
8 were to reopen another ward, I think it would have
9 looked bad. And on top of that I think that resources,
10 financially, and staff, I think there was -- I think it 12:16
11 was slightly more complicated than just going 'Right.
12 We'll remove four people from there and put them into
13 another ward', I think that that could well have been
14 considered at a higher level, but I think that they
15 wouldn't have been up for that because I don't think it 12:16
16 would have fitted in to what they were trying to do on
17 the downsizing and reducing the number. And I suppose
18 I think like a lot of the wards sort of closed because
19 patients were moving out and they needed to move the
20 staff. 12:17
21 PROFESSOR MURPHY: Okay. Thank you.
22 195 Q. MR. McEVY: At 35, you touch on something we've
23 already talked about, which is meal times, and these
24 were carried out in two sittings.
25 A. Mhm-mhm. 12:17
26 196 Q. The first was for the patients who didn't need much
27 help. The second was for patients who required
28 assistance. A level of supervision might have arisen
29 where there was a risk of choking, and staff, all

1 staff, you say, would have been aware of those risks.

2
3 "Staff breaks were staggered to make sure there was
4 enough supervision at meal times. There was one
5 patient who would have swallowed anything, meaning that 12:17
6 staff would have had to feed him. Most of the patients
7 would have had speech and language recommendations at
8 meal times, for example chopped food, mashed diets."

9
10 And of course you explain the risks posed by choking in 12:17
11 learning disability, and speech and language would
12 recommend different guidance as per the patient's needs
13 and risks.

14
15 I mean throughout our discussion this morning I've 12:18
16 asked you on a number of occasions about access to
17 other professionals. I'm thinking in particular about
18 speech and language therapists. Was there regular
19 access to them?

20 A. I know in Greenan we did, because it was kind of ever 12:18
21 changing, you know, just with the population that we
22 had on the ward. And I suppose I remember good input
23 in M4 as well. But we would have had access to them.

24 197 Q. Yes.

25 A. And it would have been regular enough contact. 12:18

26 198 Q. Okay. Right. In 36 then again you talk about Greenan,
27 and you describe again, as you have already, about how
28 it was -- you describe how it was an open ward with a
29 lock on the outside to prevent other patients coming

1 in. There was no seclusion on Greenan or M4. You
2 describe one of the restrictive practices being to lock
3 wardrobe doors to stop patients taking other patient's
4 clothes and belongings. You say there was only one
5 specific time that you recall having to use restraint 12:19
6 in Greenan. This was in relation to a female patient
7 who had come over from Cranfield.

8 A. Mhm-mhm.

9 199 Q.

10 "She had lost some of her toes due to reported 12:19
11 self-injurious behaviour before admission to MAH. When
12 it came to change the bandages on her feet she would
13 not let us and we had to hold her to change the
14 bandages."

15 12:19
16 You say obviously you were trained in MAPA, as you told
17 us previously. You only ever had to use it for this
18 patient. You recall that.

19
20 "...the decision was discussed with the doctor at ward 12:19
21 rounds. The more you tried to change the bandages
22 without using a form of restraint the more distressed
23 she became."

24
25 And this was all documented in detail. 12:19

26
27 "The incident was recorded in an incident report and a
28 body chart and it was reviewed by H209 and the
29 behaviour team. The review determined that the

1 restraint was justified as it had been previously
2 discussed and approved..."

3
4 And you believed the behaviour team looked at this
5 incident and supported staff if there were any other 12:20
6 available options.

7
8 I mean thinking back on it, do you think that in the
9 review process there was recognition that this might
10 have been, the process of wound dressing and changing 12:20
11 might have been very painful for her, it wasn't just a
12 matter of her being challenging?

13 A. Yeah. No, absolutely. If you had of -- like what was
14 under the bandages, I'm sure that she was in pain.
15 However, I suppose we had been informed by the previous 12:20
16 care where she was before she came, like what you find
17 in learning disability as well is that a lot of people
18 in learning disability have a high pain threshold, so
19 she probably was able to sustain more pain than you or
20 I, but there was absolutely no issues to say that she 12:20
21 was likely in pain. She didn't want to be bothered
22 either. I suppose, and what we had considered as well
23 is that she had just been admitted to Cranfield women
24 and then taken from there, where she had just been
25 landed in, and I think maybe a day or two later brought 12:21
26 down to us, you know, in Greenan. So like all of that
27 was considered that this is so new, you know. So we
28 just -- everything had to be considered that she was --
29 I think she had maybe been in a nursing home

1 beforehand, so from a nursing home that she was
2 familiar with, being taken from there, being admitted
3 to the Cranfield women's ward, and then being brought
4 down to us. So that was all considered that, you know,
5 this is really distressing anyway without pain, you 12:21
6 know, even before we got to the pain she would have
7 been really distressed, because she was in an area that
8 she didn't know with staff that she didn't know,
9 totally unfamiliar surroundings, and then bringing in
10 the distress of having to unravel the bandages. But 12:21
11 while trying to do the dressings she would have
12 continued to be banging her feet and her heels, and I
13 am not sure -- like I didn't...
14 200 Q. Does that mean she was at risk of causing herself
15 further injury? 12:22
16 A. Further harm, yeah, yeah. And I suppose I didn't work
17 with her that long to really know like was it sensory
18 seeking behaviours what they would talk about, as if
19 she was getting something from it, or that there was
20 something -- I think from memory I had heard later on 12:22
21 that she was actually physically unwell, and I think
22 when she would have been in Greenan we -- I remember
23 bringing her -- I remember being in Antrim Hospital.
24 201 Q. Yes.
25 A. But I can't really -- that was around the time I think 12:22
26 before -- around the time I had kind of went off work,
27 I think. So my memory isn't that good of it. But as
28 well is I don't have a great knowledge of her, but I
29 think there was something physically the matter with

1 her, and I think quite quickly when she had been in our
2 ward they were like she wasn't physically well.

3 202 Q. Yes.

4 A. And that was potentially why she was so self-injurious
5 is because she was feeling something elsewhere, you 12:22
6 know.

7 203 Q. Yes.

8 A. And that's kind of what we talked about earlier that,
9 you know, if somebody is doing something, they're not
10 necessarily just displaying this behaviour, it's as a 12:22
11 form of communication to say 'well, actually, I can't
12 explain to you why I'm feeling lousy here.'

13 204 Q. There's something else wrong.

14 A. Yeah. And that's kind of, you know, that's kind of
15 what we had thought about. But I think she I think 12:23
16 likely was physically unwell.

17 205 Q. Okay. Okay. Look, turning over to paragraph 40, just
18 for summary sake you talk about ICU and you talk about
19 how -- just before we turn to that paragraph, you talk
20 about ICU. You don't talk about it in detail. You say 12:23
21 that during your time at Muckamore there was no CCTV.

22 A. Yep.

23 206 Q. And while on Greenan and M4 you weren't involved in
24 discharge because they were long stay wards. But in
25 paragraph 40 you were heavily involved in resettlement. 12:23
26 A. Yeah.

27 207 Q. You were the named nurse for six to eight patients at
28 any one time and you were expected to go to meetings
29 about them?

1 A. Mhm-mhm.

2 208 Q. You describe a group of ladies being resettled to a
3 nursing home placement in Armagh. You worked closely
4 alongside the staff from the nursing home to ensure
5 everything went smoothly. For six to eight weeks staff 12:23
6 from the nursing home came to Muckamore to get to know
7 the ladies and their care plans. The nursing home
8 would have had their own care plans, but we would have
9 made sure everything was included. There was a nursing
10 assessment used based on the Roper Logan and Tierney 12:24
11 model of nursing. Can you tell us a wee bit about what
12 that is?

13 A. Yeah, that is a model of the nursing -- how we would
14 devise their care plans, and that incorporates all of
15 their daily, their daily activity living. 12:24

16 209 Q. Yes.

17 A. I can't speak!

18 210 Q. I think you go on then in fairness -- in fairness you
19 go on in the next sentence to say --

20 A. Oh, does it say that? Okay. Yeah. Daily living 12:24
21 activities.

22 211 Q. Yeah:

23

24 "We used to capture all daily living activities."

25

26 CHAIRPERSON: we've got to get it transcribed.

27 MR. McEVROY: Yes. So you say:

28

29 "It is used to capture all daily living activities and

1 when we were resettling patients from either Greenan or
2 M4 the families did not usually get involved."
3
4 A. Yes.
5 212 Q. Did that model -- 12:24
6 A. No, no, that's just quite a common model that's used
7 within nursing care. And just regarding the families,
8 a high percentage of them, you know, we're talking
9 about an older population, and maybe 20 or 30 years
10 prior to that the mummies and daddies would have 12:25
11 visited, but as time went on they maybe have passed
12 away and siblings didn't necessarily take as much to
13 do, you know.
14 213 Q. Yes.
15 A. I can recall like one or two of them like would have 12:25
16 said 'Youse know her better. I'm happy if youse are'
17 -- you know that way. But we wouldn't have had like a
18 big -- there would have been maybe one or two patients
19 would have had regular visits from their families, but
20 I suppose just the longer stay, they were older and 12:25
21 maybe didn't have like close relatives.
22 214 Q. I think you're talking there about the instance of a
23 patient whose sisters lived abroad and you were trying
24 to resettle her.
25 A. Aye, that's -- yeah. Yeah. 12:25
26 215 Q. The sisters were very upset because they did not want
27 their sister to leave as they viewed Muckamore as her
28 home. Can you tell us how that was resolved, that
29 situation?

1 A. Well I suppose like nobody really had a choice in the
2 matter. It was a government driven policy that people
3 were being moved out. In a less harsh way I sort of
4 discussed that with the sisters, going like, you know,
5 if I had my way she could stay here, you know, that's 12:26
6 fine, but ultimately like that's not what's happening.
7 The drive here is to get people resettled and out into
8 the community. She doesn't need to be in hospital.
9 She's not requiring any specific, you know, she was
10 going to a learning disability nursing home with 12:26
11 learning disability nurses. She didn't necessarily
12 need to be in a long stay hospital. Just a lot of sort
13 of emotional support given to like families about that,
14 you know. And that particular one, there was a group
15 of the patients that had been on the ward together for 12:26
16 a very long time, and that was kind of what I had sort
17 of said to her like, you know, the other options are if
18 she doesn't go on this one we don't know where she is
19 going to go because there has been no further nursing
20 placement identified. So I kind of had sort of felt 12:26
21 that it was the lesser of two evils that she was going
22 to be going to a nursing home with patients that she
23 knew, you know.

24 216 Q. Yes. Yes.

25 A. And like, do you know, she actually died a couple of 12:27
26 months after being out, and the sister, like what I
27 took from the sister, she was so upset and we got the
28 blame of it, you know. And I suppose like she was just
29 heartbroken, you know. She had just, I don't know, she

1 was very, very upset, but very cross at us in the
2 aftermath of that. But I suppose it's just, it was
3 just one of those things that was the nature of the
4 long stay hospital, it wasn't going to be open forever
5 and she didn't need, you know, she didn't need to be 12:27
6 there. We would have liked to have kept her there, but
7 she didn't need to be there.

8 217 Q. Of course. Of course. You tell us then that there's a
9 matrix used by care managers to identify patients
10 suitable for each placement. You weren't aware of it 12:27
11 while you were at Muckamore, but you became aware of it
12 working in the community?

13 A. Yeah.

14 218 Q. All the patients on Greenan and M4 were identified as
15 being suitable. Why would you not have been aware of 12:28
16 that matrix while at Muckamore?

17 A. Because that wouldn't -- as a Staff Nurse that I
18 wouldn't have been, you know, the level that I would
19 have been involved with is going and giving information
20 about the patient that I knew, or my named patients. 12:28
21 That matrix was they would have been, the care managers
22 would have been two grades above you as a Staff Nurse.
23 So that was kind of their like managerial sort of side
24 of things, but I wouldn't have had knowledge of -- like
25 the matrix is kind of looking to see, 'Right, well who 12:28
26 lives there currently?', and what, you know, for talk's
27 sake I could say somebody absolutely does not like loud
28 music, and then they have the matrix, you know. I
29 suppose it wasn't really my business either because

1 they would have had information of other service users
2 that I wouldn't have needed to have knowledge of, you
3 know. So I suppose from that point of view. But it
4 was only just working in the community, and knowing
5 care management, and knowing...

12:28

6 219 Q. Yes.

7 A. That's how I knew that's actually how they decide.
8 Because the question was, the Inquiry question was like
9 how were people identified? And it was kind of like
10 'well, these six ladies know each other and there are
11 six beds', it was a new place opening and there was six
12 bed. Whereas like if somebody that had like real
13 sensitivity to loud noise and they were going somewhere
14 that your man up the stairs played drums, you know,
15 they would have had that matrix to go 'that's a
16 non-runner', you know.

12:29

17 220 Q. Yes.

18 A. So they would have had more sensitive information about
19 other people that I wouldn't have necessarily needed.

20 221 Q. More relevant to the task that they had to do?

12:29

21 A. Yeah. It wasn't for me to know really.

22 222 Q. Yeah. Okay. Then in 41, and this is really just
23 finally from me, but:

24
25 "I never had any formal training on resettling patients
26 but I did not think I needed to be able to advocate for
27 patients."

12:29

28
29 Is there anything you want to add to that? In other

1 words what you're essentially saying there, if we
2 understand that correctly, is that resettlement is
3 something that comes with the job essentially?

4 A. Yeah. And I suppose like the resettlement policy, do
5 you know, it was, do you know, it wasn't anything -- it 12:29
6 was just one of those things. It was a fact of life
7 that these people were being moved out into the
8 community and, you know, I think the question was like,
9 you know, did I feel that I needed training? I didn't
10 feel I needed training on a process that was going to 12:30
11 potentially enable somebody to have a better life not
12 living in a long stay hospital. And I suppose like I
13 remember raising concerns about somebody that had been
14 identified for another nursing home and raising
15 concerns, and that was taken onboard, you know. I 12:30
16 don't know how I would elaborate on that.

17 223 Q. Yeah. I suppose maybe just -- I know I told you that
18 was my final question, but there's one that occurs to
19 me. At the very start I asked you about your current
20 post and you're in the community now and you're still 12:30
21 working in the learning disability field.

22 A. Yeah.

23 224 Q. The Inquiry has seen and heard from you at quite some
24 length this morning, but what are the attributes that
25 you describe, you know, in your last paragraph there in 12:30
26 terms of your nursing skills in Muckamore, what are the
27 attributes you think are essential for a learning
28 disability nurse going into the future?

29 A. Ehm, I suppose -- that's a really difficult question.

1 225 Q. Have a go. It's your opportunity to shine!

2 A. Yeah. No, I think though like you have to have a

3 positive attitude, you know.

4 226 Q. Yes.

5 A. We joke about looking I think as a swan, being really 12:31

6 calm on the exterior and your legs going a mile a

7 dozen, you know. You need to be that sort of calm, but

8 sure of yourself as well.

9 227 Q. Yes.

10 A. And you need to make sure -- like when I first moved 12:31

11 into the community I was like I actually really like

12 this because, you know what, you had to prove yourself

13 to the person because you were going into their home.

14 You know when I was in the hospital or a nursing home,

15 you know, you were working there, but like when I've 12:31

16 started afresh in the community you have to sort of

17 build that relationship, make it therapeutic, and make

18 it as positive and provide as much care and support to

19 the people that you're working with.

20 12:31

21 I think overall like the skills that I learned in

22 Muckamore like, do you know, like when I worked in the

23 community the social workers used to come in and they

24 would have been like 'Oh, my goodness, did you see such

25 a thing?', and there would have been a big, big panic, 12:32

26 and I was like, 'Like that's fine, don't worry about

27 it', you know. And like a lot of them would comment

28 going, you know, 'Oh, it's well seeing you come out of

29 Muckamore. Youse are much more calm', you know. And

1 they would have made jokes about it. But I think like
2 having a calm exterior, being caring, and kind and
3 professional, and doing your best, you know, you're
4 working with really, really vulnerable people, and
5 particularly out in the community you're working with 12:32
6 people -- and in the hospital as well -- you're working
7 with people with a lot of complex issues, you know.
8 People might think that they're doing this because of
9 this, but it's actually to do with something that
10 happened at a very young age that's not being 12:32
11 considered and somebody would just put a negative thing
12 going 'Oh, he's displaying' -- we had somebody, and the
13 staff in a unit were like 'he's displaying this
14 challenging behaviour. He's so difficult. He's so
15 difficult', and I was like he actually has an 12:32
16 attachment issue, and that's where a lot of these, you
17 know, and it is sort of -- a lot of it is educating as
18 well and you're sort of educating other staff members,
19 you know, of how to approach and how to look at it in a
20 wider picture rather than just zoning in. 12:33

21
22 As I said before about the behaviour stuff, you're kind
23 of looking 'well, why?', you know, 'why are they doing
24 that? why is somebody repeatedly head-butting the
25 wall?', you'd be looking to see what actually is the 12:33
26 cause of that. And I think that's important and I'm
27 very mindful when we have newly qualified Staff Nurses,
28 you know, like reassuring them a lot. Like we have
29 found ones that have come working with us recently, or

1 in the last number of years, are very nervous, and I
2 think like there's such a negative spin on learning
3 disability staff and learning disability nurses that
4 they're very nervous and concerned to be in the field
5 of nursing that we're in, and I suppose it's just
6 trying to remember.

12:33

7
8 we did a thing there a while ago like "Remember Your
9 why" is like remember why you went into nursing is
10 because you want to do the best for the people that
11 you're working with.

12:33

12 228 Q. Yes.

13 A. And particularly if they have a learning disability or
14 anything, any additional needs that makes them that bit
15 more vulnerable, that you have to do your best.

12:33

16 229 Q. H324, those are my questions. Thank you very much.

17 A. Okay. Thank you.

18 MR. McEVOY: But maybe the Panel have some more.

19 CHAIRPERSON: I think we've asked the questions as

20 we've gone along. So there's nothing more to ask you.

12:34

21
22 I just want to thank you on behalf of the Panel,
23 because certainly my view is you have been very
24 balanced in your evidence. You have been very frank.
25 You've told us exactly as you found things to be, and
26 you are sort of the witness we need. So can I thank
27 you very much for giving up so much time to come and
28 assist the Inquiry, and you can now go with the
29 Secretary to the Inquiry.

12:34

A. Thank you.

CHAIRPERSON: Mr. McEvoy I think that's you done for the day, isn't it?

MR. McEVROY: That's my stint over. Thank you, Chair.

CHAIRPERSON: Ms. Bergin, you're reading this
afternoon.

12:34

MS. BERGIN: Yes. I'm in your hands. We can make a start now or I'm happy to start at whenever your wish.

CHAIRPERSON: What we'll do is we'll take a break now because we've been sitting for quite a long time, but we might try and start a bit earlier. So if we start at 1:50. Okay. Thank you very much.

12:35

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS
FOLLOWS:

MS. BERGIN: Good afternoon.

CHAIRPERSON: Hold on. Okay. Ms. Bergin, we've got some statements to read.

13:46

MS. BERGIN: Yes. There are three statements to be read this afternoon, Chair and Panel. Two statements from Oliver Shanks and a statement from H303.

The first statement of Oliver Shanks is dated 28th June 2022. The reference is STM-031 and states as follows.

CHAIRPERSON: Okay. Hold on. Hold on. Sorry. Are you reading the whole thing into the record or are you going to precis it?

13:46

13:47

MS. BERGIN: So I'm going to precis certain parts of the statements where appropriate.

CHAIRPERSON: Yeah. Okay. Right. Sorry.

STATEMENTS OF OLIVER SHANKS REFERENCE STM-031 AND
STM244 READ BY MS. BERGIN

13:47

MS. BERGIN:

"I, Oliver Shanks, MRCP, FRCP Psych, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement.

13:47

1 My connection with MAH is that I was a consultant
2 psychiatrist at MAH. The relevant time period that I
3 can speak about is from 1982 and January 2001.

4
5 I joined MAH in 1982. This was my first consultant 13:47
6 post. I was a member of the consultant medical staff
7 at MAH. I was proud of the service delivered and
8 worked hard with others to maintain it. I have no
9 knowledge of MAH in the time after 2001. I am
10 devastated to hear the extent to which the well planned 13:48
11 resettlement programme and continuing care of the
12 patients in MAH fell apart. I am especially distressed
13 to hear about the lack of respect and understanding
14 suffered by the patients.

15 13:48
16 I note the Terms of Reference of the MAH Inquiry
17 include making recommendations regarding the training
18 of staff, the management and governance of such
19 facilities. Whilst it is important for the Inquiry to
20 examine what was done wrong, it is also important to 13:48
21 examine what was not done that would have made things
22 right. I am aware of the considerable expertise of
23 members of the Panel, but I wish to describe below
24 examples of what MAH at one time aspired to and in many
25 cases achieved. 13:48

26
27 I submit that training should emphasise that
28 interaction with patients must be respectful and age
29 appropriate. The importance of age appropriate

1 interaction cannot be over-emphasised. People with a
2 learning disability are not overgrown children, as the
3 archaic use of the term "mental age" might suggest.
4 They are people who happen to have a learning
5 disability. Specialist nurse training should have 13:49
6 multidisciplinary components, as should training of all
7 disciplines. After training there should be continuous
8 professional development. Social workers can explain
9 the importance of family and community facility
10 involvement. Speech and language therapists can 13:49
11 demonstrate and teach not only the simplified sign
12 language Makaton, but also the extent to which
13 successful non-verbal communication can be achieved.
14 Psychologists can explain how difficult behaviour is a
15 potent form of communication. Psychiatrists can 13:49
16 explain the variety of syndromes, the manifestations of
17 epilepsy and mental illness. Dieticians can explain
18 not only the importance of sensible foods but also the
19 emerging importance in certain conditions of specialist
20 diets. Several other therapeutic disciplines have 13:50
21 important contributions to make to the initial and
22 in-service training.

23
24 An important part of the training involves reviewing
25 and conducting research. Research is a potent stimulus 13:50
26 for critical observation. It can involve both senior
27 and junior staff and it requires outside scrutiny.
28 Managers should supervise staff regularly in a
29 supportive manner, not only assessing performance but

1 also eliciting concerns and anxieties.

2
3 Governance should include the physical presence on a
4 regular basis of senior staff.

5
6 I eventually left MAH in January 2001 when I retired
7 from medical practice."

8
9 The second statement of Oliver Shanks is dated 2nd May
10 2024, and the statement reference is STM-244, and
11 Dr. Shanks states at the beginning of his statement
12 that he was a psychiatrist at MAH from 1982 until his
13 retirement in 2001. Following graduation from Queen's
14 University, Belfast, in 1974, he became a member of the
15 Royal College of Physicians in 1978, and the Royal
16 College of Psychiatrists in around 1979. He worked as
17 a child psychiatrist and then joined MAH in 1980 as a
18 registrar.

19
20 There were three consultant psychiatrists at MAH at
21 that time. Dr. Scally, whom he shadowed; Dr. Moffett,
22 and Dr. Calvert. There were also Dr. H566 and Dr. H41
23 who were appointed consultants in 1986.

24
25 There was normally one junior doctor attached to each
26 consultant. Dr. Shanks became a Senior Registrar in
27 1981 and was appointed as a consultant in 1982. He
28 states that he went into learning disability
29 specifically because:

1
2 "...there was no expectation for a complete cure, but
3 rather a desire for a better long-term outcome for the
4 patient..."

5
6 - and he wanted to be part of the instigation of change
7 in societal attitudes to learning disability which were
8 occurring at that time.
9

10 Picking up at paragraph 6, Dr. Shanks continues:

11
12 "Within MAH I was based in the administration building.
13 I was on site at MAH every day. I would either do a
14 morning or an afternoon session. As well as being in
15 MAH I had a clinic within the Belfast Trust at 17
16 Wellington Park, Belfast. If I was not in MAH in the
17 morning or the afternoon, I would be in the clinic.
18

19 I successfully applied to become a consultant
20 psychiatrist in MAH in 1982. My office was based in
21 the administration building but I would treat patients
22 from particular wards. I was initially assigned to
23 treat patients on the Conicar and Clonshee Wards as
24 these wards were children's wards, and the hospital
25 wards, Rathmore and Rathmullan, because of my
26 qualification in physical medicine. I then began to
27 treat patients on a long stay adult ward, a male
28 admissions ward, Movilla, and a Forensic Ward, Mallow.
29

1 During my training to become a psychiatrist at
2 postgraduate level, part of the course was learning
3 disability specific. This was completed in MAH and
4 St. Georges Hospital, London, with Professor Bicknell
5 and Dr. (lately Professor) Sheila Hollins. The 13:53
6 training which I undertook in working towards my
7 membership of the Royal College of Psychiatry contained
8 specific sections on children's learning disability,
9 old age and general psychiatry. I did also complete
10 other forms of learning disability training, 13:54
11 specifically during my first post as a registrar when I
12 worked in Purdysburn Hospital."

13
14 And Dr. Shanks states that he would have got an
15 afternoon off to visit MAH for this training. 13:54
16

17 "I recall that I visited MAH before I commenced working
18 at the hospital. I recall that it was a good facility
19 and I remember being impressed. I liked the people I
20 was working with and I liked the patients. I recall 13:54
21 that Dr. Scally had a very good reputation when I went
22 to work in MAH in 1982. Back then, in the 1980s, the
23 hospital was very modern, there was a swimming pool on
24 site and a day care centre. I recall that the cafe was
25 introduced at a later date, supported by the parents 13:54
26 and friends, but I cannot recall when.

27
28 During my time in MAH I would see patients every day,
29 sometimes this would be in an office located in the

1 administration building or in a consultation room on
2 the ward they were in. Every day in MAH was different.
3 I would see patients depending on the needs of the
4 individual patient. There were ward rounds carried out
5 every week for which I would have been present and I 13:55
6 would also informally bump into patients and have a
7 chat with them. If during the ward rounds something
8 cropped up, I would have met with the patient. Other
9 times, I would have met with the patient at a planned
10 appointment. I worked in MAH between the hours of 13:55
11 9:00am to around 6:00pm, but occasionally I would have
12 visited the hospital at night to make sure everything
13 was okay."

14
15 Dr. Shanks then recalls an example of a mother of a 13:55
16 profoundly disabled child patient who was in tears,
17 having been told that the disability had been caused by
18 the mother's failure to live up to her religious
19 beliefs.

20 13:55
21 Dr. Shanks continues:

22
23 "I recall that patients always had more than just
24 medication on their treatment plans. Medication was
25 just part of a wider plan. The medication element of 13:56
26 the treatment plan came from the medical team. I would
27 have contributed to this as a psychiatrist. Social
28 workers, along with families and the patients
29 themselves, would have contributed to the treatment

1 plan. The plans were structured to be
2 multidisciplinary. I recall there was a pharmacist on
3 site at MAH, but I do not recall that they ever had a
4 direct input to the treatment plans. I believe they
5 were involved in the formulation of the medication and 13:56
6 were available for advice. When I was a registrar, I
7 had an input towards the treatment plan of the
8 patients. If something was more complex that I felt I
9 could not do myself as a registrar, I would have
10 discussed this with the consultant. On occasion, when 13:56
11 I was a consultant, I obtained a second opinion on a
12 patient if there was a condition which was particularly
13 difficult to treat.

14
15 The primary treatment options were different for every 13:57
16 patient and these would depend on what the individual
17 needed treatment for. For example, if a patient
18 suffered from epilepsy I would prescribe medication.
19 However, if a patient had behavioural issues I would
20 direct they were treated with behavioural methods. On 13:57
21 occasion, I would prescribe medication in addition to
22 the behavioural methods.

23
24 Again, in relation to the use of primary therapeutic
25 interventions, these would have depended on the 13:57
26 individual patient. I recall the interventions that
27 were used would be psychotherapy, talking therapy,
28 medication, social interaction and behavioural therapy.
29 Therapeutic intervention itself is also a form of

1 treatment. It was my role as a consultant to ensure
2 they were used appropriately and I would have relied on
3 my professional training and experience to assess this.
4 I recall the introduction of group therapy, but this
5 took a while to establish. Psychotherapy was gradually 13:58
6 introduced during my time in MAH and I was part of the
7 piloting for this. The application of psychotherapy
8 was gradual.

9
10 I recall that in my initial years there was an issue 13:58
11 with overcrowding in MAH. I recall that some patients
12 would sleep out. Patients on a ward would spend the
13 day in their ward and then would be moved to a
14 different ward to sleep as there was not enough room
15 for them as there were new admissions. The newly 13:58
16 admitted patients would stay on the same ward day and
17 night and the patient who was maybe ready for
18 resettlement would have been moved to sleep out on
19 another ward.

20 13:58
21 During my time in MAH the general relationship between
22 staff and families was good and developed further. The
23 general attitude towards learning disability changed.
24 People with a learning disability used to be referred
25 to as "mentally handicapped" and the change of this 13:58
26 phrase reflected a wider societal change. There was a
27 change with the introduction of special education too.
28 I felt these were positive changes which reflected
29 improvement in the treatment of learning disabilities.

1
2 I recall when I worked on the Conicar Ward, which was a
3 children's ward, most patients were in their late
4 teenage years. Some of the staff members tended to hug
5 the patients when greeting them. I insisted on shaking 13:59
6 their hands when I greeted them as it was more
7 appropriate with young adults. I understand that this
8 was more the societal attitude at the time, i.e. to
9 treat the patients like they were all children. I felt
10 that this culture changed during my time in MAH for the 13:59
11 better.

12
13 After a patient was admitted to MAH, as a consultant I
14 would have been involved in developing the care plan.
15 The process began at ward level. There were several 13:59
16 disciplines involved in the adaptation of the new care
17 plan during the patient's period of care, such as
18 medical, social workers and nursing.

19
20 During my time in MAH there was always a nursing 14:00
21 hierarchy. There would be experienced senior nursing
22 officers who would be in charge of multiple wards, then
23 charge nurses in charge of a ward, and staff nurses.
24 This appears to have changed since I left MAH. I think
25 this hierarchy worked well. We all worked well 14:00
26 together. We would on occasions have robust
27 discussions but they were constructive.

28
29 As a consultant I would have attended weekly ward

1 rounds as part of the multidisciplinary team. These
2 meetings were conducted in a consultation room and
3 involved discussing each patient on the ward in turn.
4 Present would have been myself, a social worker, a day
5 care worker and I recall at one stage there was a 14:00
6 dietician involved. I was in attendance as part of the
7 medical discipline. I recall that on occasions a
8 psychologist would be present. They are not medical
9 doctors but they might have a PhD.

10
11 I recall that once a month an orthopaedic surgeon would
12 have visited the site, his name was Mr. James, as
13 occasionally orthopaedic intervention was necessary.
14 The medical representation at the MDT meetings would
15 involve the consultant psychiatrist and the junior 14:01
16 doctor who was attached to that consultant.

17
18 I recall that patients would sometimes attend the MDT
19 meetings but they would not stay for the entirety of
20 the meeting. Patient advocates were only being 14:01
21 introduced at MAH when I left in 2001, so I did not
22 experience them.

23
24 I had a good relationship with the on-site management
25 team at MAH. I felt supported. The most senior 14:01
26 manager on site at the time I started was Bill Canning.
27 Later there was Norma Heatherington and Miriam
28 Somerville. My interactions with the management on
29 site were not frequent. They would involve casual

1 meetings which would have taken place in the
2 administration building but they were not formal
3 meetings.
4

5 The Datix system was introduced at MAH after I retired 14:02
6 in 2001. During my time in MAH there would have been a
7 system in place for recording serious incidents,
8 however, I was not involved in compiling the reports.
9 Before Datix I believe these would have been recorded
10 on paper and, if an incident had taken place, I would 14:02
11 have seen the report for the purpose of me being kept
12 informed. I cannot recall a particular time I would
13 have seen these documents, nor can I recall how
14 frequently I would have reviewed these documents. I
15 would have received the documents from the nursing 14:02
16 staff rather than have requested to see them.
17

18 I recall at MAH there were a number of external
19 specialists available for consultation in complicated
20 matters. Around 30% of people with a learning 14:03
21 disability suffer from epilepsy. This was the same for
22 the patients in MAH. Most of the time the epilepsy was
23 easy to control with medication. However, a
24 neurologist's opinion was sometimes needed. If I did
25 not think I could manage a case of complex epilepsy on 14:03
26 my own I would have sought help from another
27 consultant. I might also seek a second opinion in a
28 case of treatment resistant psychosis. This would not
29 have been frequent. There were no criteria as to when

1 a patient would be referred for a second opinion from a
2 consultant or hospital. It was case specific to each
3 patient. I would have made a referral if I thought I
4 needed advice or could not manage the patient myself.

14:03

6 I recall that I would have been made aware when
7 seclusion, physical intervention or sedation was used
8 on a patient. I would have been made aware by the
9 nursing staff on the ward, I would have been told when
10 the incident had occurred at the ward round or at the
11 weekly MDT meeting. The incident would have been on
12 the agenda for the MDT meeting. I recall that PRN
13 medication was used when required, but it was not
14 encouraged for behavioural problems. My role as a
15 consultant was to ensure that these methods were used
16 appropriately. If they were being used inappropriately
17 I would have relayed this back to the staff in
18 question. The issue was usually that the methods had
19 not been used. For example, a situation that required
20 the use of PRN medication and it was not used."

14:04

14:04

14:04

22 Dr. Shanks doesn't recall any specific incidents
23 seclusion was an alternative to PRN medication and he
24 states that it generally wasn't used.

14:04

26 "The term "safeguarding" was introduced after my time
27 in MAH but there must have been an equivalent when I
28 was there. I would not have been involved directly but
29 I would have contributed if required. Usually the

1 issue would have been initiated elsewhere by the social
2 worker or a member of MAH staff of another discipline.
3 If there was a general discussion around the
4 safeguarding of a patient I would have contributed.

14:05

6 As far as I can recall the positive behaviour support
7 plan for patients would have been part of the general
8 treatment plan. Cognitive Behaviour Therapy (CBT), was
9 only just being introduced in MAH around the time I
10 left. I recall that CBT would have been psychology led
11 but that medical staff would have been involved in
12 this. I recall that there was training for this and I
13 attended one or two training sessions before I left.

14:05

15 I cannot recall that during my time there were any
16 specific polypharmacy reviews, however medication of
17 patients would have been reviewed at the weekly MDT
18 meetings.

14:05

20 During my time in MAH, learning disability was still
21 going through societal change. I left MAH in 2001 and
22 learning disability was part of the general societal
23 change at that time. A few families were reluctant for
24 their member with learning disability to be discharged
25 from MAH. Now, as I understand it, society is
26 beginning to see people with a learning disability as
27 adults and not as perpetual children.

14:05

14:06

28
29 During my time in MAH I would have always welcomed and

1 encouraged family's input in regards to the patients
2 and their treatment. My contact with families would
3 have varied as some families were more involved than
4 others. My contact would usually have been with
5 families that wanted to be involved. Occasionally I
6 would have pushed for more involvement from families,
7 but they did not want to be involved. I recall that
8 there were some families that were involved to an
9 extent that proved extremely difficult.

14:06

10
11 If a family wanted to be involved with a patient I
12 would have discussed issues and medication with them,
13 preferably face to face. This would have been my
14 preference but some families found it more convenient
15 by telephone. If this was the case I would have made a
16 note of this in the notes. At this time all notes were
17 paper notes. After I had discussed anything with the
18 family I would have recorded this myself. Consultants
19 did use secretaries, but this was more for sending out
20 letters and arranging appointments.

14:06

14:07

14:07

21
22 If a family member had raised a concern with me about a
23 patient I would have referred this to the ward staff.
24 I cannot recall any specific incidents where a family
25 member made a complaint to me. However, if a complaint
26 was made about a particular member of staff, I might
27 have met with the nursing staff and the family member
28 together, if it was appropriate.
29

14:07

1 In relation to overmedication, it was my role to ensure
2 that this would not happen in the first place.

3 I cannot recall during my time that any family member
4 made a complaint about their relative who was a patient
5 in MAH being overmedicated. This is not to say that it 14:07
6 did not happen, I just cannot recall any specific
7 incident. I do recall that at times there was
8 difficulty in controlling specific conditions.

9
10 I recall that from the outset I had a good working 14:08
11 relationship with the nursing staff and I worked in
12 good partnership with the Ward Managers. I recall that
13 the attitude and conduct of the staff reflected the
14 nature of the patient. Each ward had a different

15 culture as each ward dealt with various different 14:08
16 abilities. For example, the Rathmullan and Rathmore
17 Wards were more hospital wards where the patients were
18 bedbound. I worked in both of these wards. I also

19 worked on the Forensic Ward where I shared
20 responsibility for this ward with Dr. Maginnity. We 14:08
21 worked alongside the senior nurse, Sister Devlin. I
22 recall the three of us worked well together. This ward
23 was more progressive than the other wards as patients
24 were more able. This made it easier to introduce

25 talking therapies on the ward and social activities. I 14:09
26 recall that working on the Forensic Ward posed more
27 difficult at times. The problems the patients
28 presented were different. You were put into a
29 situation that had given rise to what social constraint

1 they were under. For example, where the patient was
2 acting inappropriately we tried to help them cope.

3
4 I recall that there were nursing officers who were in
5 charge of one or more wards at a time. My relationship 14:09
6 with staff members and the nursing officers was good.

7
8 As a member of staff in MAH I underwent training in
9 restrictive practices. I do not recall ever having to
10 be involved in any restrictive practices. I believe 14:09
11 that the term "restrictive practice" was introduced
12 after my time in MAH. As far as I can recall the use
13 of seclusion and administering medication was the
14 responsibility of the nursing staff. However, the
15 medical team, consultants, would have prescribed the 14:09
16 medication. If I was present on a ward when seclusion
17 or medication was being administered I would have
18 expressed an opinion, but that was the extent of my
19 input. I recall on one occasion a male patient was
20 presenting as self-abusive. I was present for this 14:10
21 incident while he was being restrained. He had
22 required treatment at a secure hospital in Scotland. I
23 recall his name was P215. I was involved in the
24 decision-making process regarding this incident. I
25 prescribed new medication to him and he was eventually 14:10
26 successfully resettled into a community placement.

27
28 I recall one occasion when a member of nursing staff
29 had an opinion that was critical of my work. His

1 opinion was that I had discharged a patient too early.
2 The member of nursing staff in this instance was right
3 and I could have done better. Thankfully the situation
4 worked out well in the end for the patient.

5
6 I recall one tragic incident occurred during my early
7 days in MAH where the bath water was too hot and a
8 young patient got burnt as a result. The nurse was
9 disciplined. I remember I went to speak to her and I
10 was perceived by her nursing manager to be
11 over-supportive. The nurse in charge felt that I was
12 more supportive than I should have been towards the
13 nurse, this was business between the nurses and I would
14 just leave them to it.

15
16 I recall that I wanted to introduce more parental
17 involvement. There were associate specialists in the
18 hospital, they were elderly doctors or doctors who were
19 not in training posts. They were there to provide
20 general medical care. I recall that when I wanted to
21 introduce the more parental involvement I received
22 resistance from them. This slowed down the
23 introduction of more parental involvement with the
24 patients, but I did not raise any concerns at this time
25 as the team were slowly phasing out and, although it
26 slowed down the process, things were still moving
27 forward. These general medical doctors were present
28 during my early days in MAH and I recall that they
29 eventually retired. Once they were phased out it was

1 the responsibility of the consultants and trainees to
2 provide general medical care.

3
4 The allegations of extensive abuse occurred long after
5 I had left MAH. I recall that there were occasionally 14:12
6 allegations of abuse during my time, but these were
7 infrequent and were managed appropriately. I do not
8 recall any specific incidents of this type however.

9
10 During my time in MAH, I was involved in dealing with 14:12
11 complaints from patients relatives. I recall there was
12 one specific incident, I cannot recall when, with a
13 patient, I cannot recall the name, who had a bite mark
14 on them which was noticed by the parents. I remember
15 being a party to the investigation of this injury. I 14:12
16 recall that we got an opinion from a dental specialist
17 to see if we could identify who did this.

18 Unfortunately, there was no resolution to this
19 investigation. I recall that as a consultant, parents
20 would approach me to make complaints. I do not recall 14:12
21 any specific incidents, however, I recall that parents
22 were always satisfied that everything that could have
23 been done was and the relationship carried on
24 successfully between that staff member and the parents.

25 14:13
26 I understand that both talking therapy and
27 psychotherapy did evolve after my time in MAH. I also
28 understand that parental involvement with patients
29 developed considerably towards the end of my time at

1 MAH and after. During my time in MAH I helped develop
2 patients discharged to the community. I contributed to
3 this by being part of a project that ran in
4 Carrickfergus. I recall that two nursing staff members
5 from the Conicar Ward..."

14:13

6
7 - who Dr. Shanks names:

8
9 "...set up a successful nursing home in Ballyclare and
10 a number of patients from MAH went there and were
11 supported. They set up the nursing home to encourage
12 and support patients being discharged from the
13 hospital. During my time in MAH a consultant
14 ultimately had to be involved in the discharge of
15 patients.

14:13

14:14

16
17 There is a distinct difference between discharge and
18 resettlement. To me, resettlement was when someone
19 came in for treatment, was treated, got better, stayed
20 for some time and then left MAH to a setting different
21 from the one from which they were admitted. Discharge
22 was more that the patient would return to the setting
23 they had come from. In my role as consultant I was
24 more involved from a hospital point of view rather than
25 the community. I do recall on occasions I would have
26 followed up with some patients who had been resettled
27 to the community.

14:14

14:14

28
29 My time at MAH was hard work but it was something

1 different every day and I enjoyed that."

2
3 The final statement to be read is from H303. Chair, a
4 Restriction Order, No. 74, was granted by you on 28th
5 of April in respect of this witness that they be 14:15
6 referred to by their cipher rather than by name.

7 CHAIRPERSON: But that's it?

8 MS. BERGIN: Yes, that's the extent of the Restriction
9 Order, Chair. And the reference is STM-211.

10 CHAIRPERSON: I mean just to make it clear, the reason 14:15
11 that those restriction, or that type of Restriction
12 Order is necessary, is that although somebody may have
13 been given a cipher in the past from a precautionary
14 point of view, when they actually come to give evidence
15 they need to apply for a Restriction Order. 14:15

16 MS. BERGIN: Thank you, Chair.

17
18 STATEMENT OF H303 REFERENCE STM-211 READ BY MS. BERGIN

19
20 MS. BERGIN: The statement is dated 19th April 2024, 14:15
21 and states:

22
23 "I, H303, make the following statement for the purpose
24 of the Muckamore Abbey Hospital Inquiry.

25
26 There are no documents produced with my statement. 14:15
27 My connection with MAH is that I was employed as an
28 occupational therapist at various grades as set out
29 below from 2017 to 2023. The relevant time period that

1 I can speak about MAH is approximately between October
2 2017 when I commenced my employment at MAH and December
3 2023."

4
5 The witness then outlines that they qualified as an
6 occupational therapist in July 2016 and they are
7 registered under the Health and Care Professionals
8 Council and the British Association of Occupational
9 Therapists.

14:16

10
11 Prior to their employment at MAH they had experience of
12 working in an educational and residential college for
13 service users with learning disabilities.

14:16

14
15 The witness began working in MAH in October 2017 and
16 worked as a Band 5 agency occupational therapist for 18
17 months. They had an on-site induction with a Band 6
18 occupational therapist, which included introduction to
19 the assessments used in MAH and the wider Occupational
20 Therapy Team who were based within the community
21 learning disability team. Their first impressions were
22 that MAH was well equipped and inviting.

14:16

14:17

23
24 Picking up at paragraph 8:

25
26 "As part of the Band 5 occupational therapy role, I
27 completed the majority of my visits on Cranfield 2
28 Ward. However, I was expected to cover all wards as
29 and when requests came through to the Occupational

14:17

1 Therapy Department.

2
3 My role included assessing personal and domestic
4 activities of daily living and assessing if the use of
5 aids or equipment could be beneficial in improving a 14:17
6 client's independent function. For instance, if
7 someone struggles to mobilise short and long distances,
8 the use of a wheelchair may be beneficial. It would be
9 the role of the Occupational Therapy Department to
10 assess and follow the regional agreed pathway to 14:17
11 procure an appropriately assessed wheelchair. Or, for
12 example, if one of our clients struggled to maintain a
13 standing position for the period of a shower, the use
14 of a shower chair may be beneficial and again would be
15 the responsibility of the Occupational Therapy 14:18
16 Department to assess.

17
18 When attending the ward environment, I spoke with the
19 nurse in charge or a member of the ward team to glean
20 any relevant information required. For instance, if 14:18
21 going to complete an assessment and the client had been
22 awake for a large proportion of the night shift, then
23 it perhaps was not the time to get a fair
24 representation of function. We rely on our nursing
25 family colleagues to share accurate information. 14:18
26

27 When completing assessments within the ward environment
28 in regards to personal activities of daily living, for
29 instance showering, these were generally completed

1 alongside the health care support worker as they
2 generally completed these activities on a daily basis
3 and knew the client's routines and more importantly
4 triggers that may be associated with activities.
5 Following the assessment, on occasion we would suggest 14:19
6 alternatives in relation to pieces of equipment. For
7 instance, the use of a jug when completing hair rinsing
8 tasks. The Healthcare Support Worker would be able to
9 advise on whether the piece of equipment had been
10 trialed in the past and their impression of the 14:19
11 alternative equipment. With the nursing staff we
12 collaborated to consider if it would be of benefit to
13 trial the aid or piece of equipment. We relied on our
14 nursing family, registered nurses and health care
15 support workers, to follow through with recommendations 14:19
16 we made and encourage service users to utilise the aid
17 or equipment. On occasion the client and staff member
18 on follow-up may have advised that the aid was not
19 beneficial. For example, the introduction of a pumped
20 bottle for shower gel or shampoo may not have increased 14:19
21 function or dexterity and may not have improved the
22 independence within the activity."

23
24 The witness then describes their role in running
25 various groups at MAH which were well received by 14:20
26 wards, often facilitated alongside different
27 disciplines, and gives the example of a six week Money
28 Matters Group with psychology colleagues which tried to
29 increase patients' awareness of money.

Picking up at paragraph 13:

"When considering participants for our groups we discussed the individuals with the nurses within the ward environment. For instance, the client's named nurse, Deputy Ward Manager or Ward Manager. The information was always beneficial and we were able to discuss risks and vulnerabilities, as well as whether there were any safeguarding issues between peers that we needed to be aware of. We completed risk assessments to reflect the risks and documented how we felt it would be appropriate to mitigate the risks. If including patients from more than one ward, we brought it to the multidisciplinary team meeting to get the opinion from the wider team."

The witness then states that the Occupational Therapy developed groups to benefit clients at MAH. A breakfast club "Watch me grow" was developed to increase awareness of horticultural and cooking where patients planted seed and then grew and cooked vegetables. The witness states that:

"Creating roles and responsibilities is a key area of an occupational therapist in encouraging clients to increase and maintain function and that some of the group had continued to take responsibility outside of weekly sessions."

1
2 The witness states that they applied and in March 2019
3 were appointed as a Band 6 Specialist Occupational
4 Therapist. Around February 2022 they took up a Band 7
5 Team Lead Occupational Therapist maternity cover post. 14:21

6
7 At paragraph 17:

8
9 "During my employment within MAH as an occupational
10 therapist, an occupational therapy technical instructor 14:22
11 (OTTI) Band 4 was in post. It was their responsibility
12 to assist the occupational therapists in assessing
13 personal and domestic activity skills, as and when
14 intervention plans were created and the OTT, under the
15 occupational therapist direction, assisted in working 14:22
16 through the intervention plans. For instance, if the
17 goal was to improve an individual's cooking skills, the
18 OTTI was able to complete a session on a regular basis,
19 working through different cookery skills, with the aim
20 that the client would become proficient in tasks to 14:22
21 gain independence in cookery tasks even for one meal a
22 day (a sandwich for lunch or putting together their
23 breakfast). Our OTTI returned to the office following
24 sessions and completed a handover of the session. The
25 OTTI understood the importance of advising the nursing 14:23
26 staff and Occupational Therapy Team if any issues arose
27 within the session.

28
29 Following all contacts (direct or indirect) with

1 clients, notes were completed to reflect the session.
2 These were entered within PARIS in the relevant area
3 and were visible within the PARIS system.
4

5 The occupational therapy role also consists of 14:23
6 assessing environments specifically for clients needs.
7 This involves assessing function in relation to
8 personal activities of daily living, including
9 toileting, showering, transfers, mobility, and taking
10 into consideration aids and equipment that may be 14:23
11 required to support function. The assessment of each
12 of these areas would influence environmental
13 recommendations.
14

15 The Occupational Therapy Team was part of the wider 14:23
16 multidisciplinary team which included physiotherapy,
17 speech and language therapy and dietician, who all
18 contributed in the weekly meetings. For a period of
19 time this changed to a Purposeful In-Patient Admission,
20 (PIPA), which was a daily meeting completed on the 14:24
21 ward. Given the number of occupational therapy staff
22 members and the number of wards, it was not feasible to
23 complete this on a daily basis, therefore, we attended
24 each ward on a particular day with other professionals
25 attending the others and, if needed, information could 14:24
26 be shared following the meeting. These slowly reduced
27 in frequency to become bi-weekly and then subsequently
28 a weekly meeting again. Representation from
29 occupational therapy services generally remained at

1 once weekly with specific patient meetings sitting
2 outside of the ward multidisciplinary team and
3 attendance at these was as and when relevant to
4 occupational therapy discussion.

14:24

5
6 Within the Occupational Therapy Team, if any concerns
7 needed to be raised we brought them through on the day
8 to the Ward Manager and they were discussed and
9 reflected in safety briefs. For instance, if it had
10 been recommended that a client use a non-slip mat for
11 increased independence during feeding activity and it
12 had not been seen by the Occupational Therapy Team
13 being utilised when on the ward, then this would have
14 been raised with the Ward Manager to ensure that all
15 staff understood the function of the non-slip mat.

14:25

14:25

16
17 Occupational therapy processes include the completion
18 of an information gathering exercise, an assessment,
19 compilation of a list of aims and objectives. If
20 possible, in conjunction with the client, and
21 evaluation following the intervention. If the client
22 is being considered for a community placement we would
23 often complete an occupational therapy report which
24 would encompass background information, functional
25 abilities, engagement in activities, sensory
26 assessment, if required, and environmental assessment.

14:25

14:25

27
28 We, as the occupational therapy profession, did not
29 feed into the nursing care plan, and that was the

1 responsibility of the nursing team to complete their
2 own care plan. We assisted in the development of
3 Positive Behaviour Support plans with generally the
4 Positive Behaviour Therapist completing the support
5 plan with us adding information in relation to
6 function, and consideration of some of the sensory
7 activities that the client may find beneficial.

14:26

8 An example of a restrictive practice that I was
9 involved in was the implementation of a pinpoint belt
10 cover of an individual's wheelchair. The client lacked
11 safety awareness and had the dexterity to open belt
12 covers and didn't understand the risk coming out of the
13 wheelchair may have placed on her if on the footpath.
14 The use of the pinpoint belt was agreed within the
15 wider multi-disciplinary team alongside family input.
16 Alternatives were trialed prior to the pinpoint belt
17 cover given the restrictive nature, however, due to the
18 dexterity of the client none were effective in
19 maintaining safety. This continued to be reviewed and
20 it was documented that the pinpoint belt would be used
21 for the least amount of time.

14:26

14:26

14:27

22
23 Our team's working hours are Monday through Friday,
24 8:00am to 4:00pm. There were occasions that we did
25 attend earlier or stay later, for example, a client may
26 have engaged in their personal hygiene morning routine
27 prior to 8:00am. There may also have been urgent
28 requests on a Friday afternoon whereby we would have
29 ensured there was a contingency plan for over the

14:27

1 weekend timeframe and the review would have been
2 completed on Monday morning on the clinician's return.
3 For example, one Friday afternoon we had been made
4 aware that a client's mobility had deteriorated to the
5 point where a wheelchair would be beneficial for
6 mobility. Occupational therapy did not maintain a
7 stock of wheelchairs but we knew of a few wheelchairs
8 around the site that were non-client specific and
9 obtained one of them for the client. The client's
10 mobility was reviewed alongside physiotherapy
11 colleagues on the following Monday morning.

14:27

14:28

12
13 In terms of engaging with families, this was dependent
14 on each family. Given our general working hours we did
15 not always see families. However, if we needed to make
16 contact I understood where to locate the contact
17 details or could have passed information through the
18 nursing team who had more regular contact with family
19 members.

14:28

20
21 It is our own responsibility to maintain our continuing
22 professional development. The Belfast Trust
23 facilitated us with the opportunity to maintain
24 corporate and professional specific training events.
25 As previously mentioned, as an occupational therapist
26 we have the professional responsibility in maintaining
27 our professional registration and we re-register every
28 two years through the HCPC, having to confirm that we
29 have maintained our professional code of conduct and

14:28

1 continued with our own CPD. Upon starting my
2 employment with the Belfast Trust I was invited to
3 complete the corporate induction in Belfast City
4 Hospital.

5
6 Within the Occupational Therapy Team we completed
7 supervision within a timely manner. This included a
8 variety of types including; one-to-one formal
9 supervision, peer supervision within our wider
10 Occupational Therapy Team, and informal supervision
11 within the office.

12
13 When I started in MAH as an agency Band 5 occupational
14 therapist, the CCTV cameras were functioning. There
15 were cameras within our office environment and signs at
16 the front door of the building to advise they were
17 installed and functioning. I am aware that within the
18 ward environment CCTV covered the communal areas and
19 were not installed within the bedroom, en suite and
20 bathroom environments, given the personal nature of
21 these rooms.

22
23 Our Occupational Therapy Team was managed by the
24 Assistant Service Manager for Learning Disability
25 Occupational Therapy Services. The ASM did not
26 geographically sit within MAH but there was always a
27 way to get in contact if there were any urgent
28 questions. The ASM did make contact with MAH on a
29 regular basis and it was an invaluable source of

1 support.

2
3 The Occupation Therapy Team has an office within the
4 Moyola day services building."

5
6 And the witness describes how they were unable to see
7 anything on site from that office.

8
9 "During my time within the in-patient Occupational
10 Therapy Team I would say it has been a tight knit team 14:30
11 that has worked closely with one another, utilising
12 each other for our strengths within our daily work. We
13 bounced ideas between each other and often came up with
14 creative solutions.

15
16 When changes were made within the hospital profile,
17 Occupational Therapy were not generally included within
18 the discussion. I recall on an occasion occupational
19 therapy were asked to assess a change in ward
20 environment for a number of clients and advised of any 14:31
21 adaptations would be required at the end of the week
22 before the schedule moved. Thankfully at that point
23 there were no adaptations were required. We generally
24 heard of on-site developments in the likes of
25 multidisciplinary team meetings. 14:31

26
27 During my employment there were a number of senior
28 management changes. This generally brought a different
29 style of communication with the staff team as a whole.

1 I remember there were meetings for all staff members to
2 attend and they would inform staff of ongoing issues
3 and developments and, as referenced above, at other
4 times some decisions would filter down through the
5 multidisciplinary team meetings."

14:31

6
7 And the witness then states that to progress their
8 career they moved to work within the Trust Community
9 Learning Disability Team and they do not provide any
10 input to MAH, and that they thoroughly enjoyed their
11 employment within MAH, and then provides the usual
12 declarations in relation to their statement.

14:32

13
14 So Chair and Panel, that concludes the reading of the
15 three statements for this afternoon.

14:32

16 CHAIRPERSON: That's fine. Thank you. I think
17 tomorrow we've got one longish witness. But nothing to
18 be read tomorrow? We might. Well, okay. But we can
19 start at 10:00 tomorrow. Yep. Okay. Thank you very
20 much. Okay everybody, we'll start at 10:00 o'clock
21 tomorrow morning. Thank you for your attendance today.

14:32

22
23 THE INQUIRY ADJOURNED UNTIL TUESDAY, 4TH JUNE 2024, AT
24 10:00 A.M.