

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

HEARD BEFORE THE INQUIRY PANEL
ON MONDAY, 9TH OCTOBER 2023 - DAY 64

64

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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 BL MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MR. JAMES TOAL 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 MR. SEAN MULLAN BL
INSTRUCTED BY :	PHOENIX LAW SOLICITORS
FOR GROUP 3 :	MR. CONOR MAGUIRE KC MS. VICTORIA ROSS BL
INSTRUCTED BY :	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:

MRS. SARA ERWIN
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

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1 THE INQUIRY RESUMED ON MONDAY, 9TH OCTOBER 2023 AS
2 FOLLOWS:

3
4 P34'S MOTHER SWORN

5
6 CHAIRPERSON: Thank you very much. Are we using
7 ciphers throughout, Ms. Kiley?

8 MS. KILEY: First names, Chair. So ^{P34's mother} and the
9 patient may be known P34

10 CHAIRPERSON: I am going to call you ^{P34's mother} if I may. 10:15
11 Can I just welcome you to the Inquiry and thank you
12 very much for making a statement, which is now going to
13 be read so if you listen carefully. I'm sure you know
14 it pretty much backwards by now but if you will just
15 listen carefully and then you will be asked to confirm 10:16
16 that that's the statement you want to make. All right.
17 So welcome to you, welcome to your daughter and we will
18 now hear the statement read.

19
20 P34'S MOTHER'S STATEMENT READ: 10:16

21
22 MS. KILEY: I should say, Chair and Panel, you will
23 see that the witness is accompanied by her Family
24 Liaison Officer who is known to the Inquiry.

25 CHAIRPERSON: Yes. 10:16

26 MS. KILEY: ^{P34's mother} good morning again, you and I met
27 briefly earlier this morning, and I explained the
28 procedure that we'll adopt today in giving your
29 evidence. So, as you know, you have made a statement

1 to the Inquiry and the first thing that I am going do
2 is read that allowed into the Inquiry record. You have
3 a copy in front of you, if you would like to follow
4 along when I'm reading. When I am reading, you will
5 notice that I won't say certain names and instead I 10:16
6 will be reading out a cipher and in front of you, you
7 also you have a cipher list so that will enable you to
8 follow on to check who I am referring to if you wish.
9

10 I also explained to you this morning that the PSNI made 10:17
11 an application for a Restriction Order in respect of
12 some of the paragraphs of your statement and I have
13 already explained to you what that means, I am not
14 going to go through that again. But the Chair has now
15 made that order. So if I miss over some paragraphs you 10:17
16 will know that that's why and we will deal with that
17 later in a closed session. Okay. And are you ready
18 for me now to commence reading?

19 A. Yes.

20 MS. KILEY: Okay, thank you. So you have made a 10:17
21 statement to the Inquiry which is dated the 25th of
22 September 2023 and you say:
23

24 "I, ^{P34's mother} make the following statement for the purpose
25 of the Muckamore Abbey MAH Inquiry. In exhibiting any 10:17
26 documents I will number each so my first document will
27 be Exhibit 1.
28

29 My connection with MAH is that my son, P34 was a

1 patient in MAH. The relevant time periods that I can
2 speak about is March 2005 to 2007, and 2009 to June
3 2023.

4 I am the mother of P34 who is 29 years old.

5 P34 spent his early childhood at home with his 10:18
6 family, me, his daddy and his sister P34's sister who is
7 about four years older than him. P34's sister is also
8 providing a statement to the Inquiry. P34 has a
9 large extended family, he is loved and has always been
10 fully included in the family. I attach at Exhibit 1 a 10:18
11 photograph of P34

12
13 I would describe P34 as a good baby. He was a very
14 compliant wee boy who slept a lot. P34 was
15 premature and born a month early via emergency 10:18
16 caesarian section. P34 suffered from reflux at
17 birth which is still present today. P34 also
18 suffered from a range of breathing difficulties in his
19 first years of life. However, overall he was largely
20 hitting his developmental milestones and was able to 10:18
21 walk and babble.

22
23 P34 did have some issues with his fine motor skills
24 and engaged in body rocking. When P34 was two and
25 a half to three years old, me and my husband became 10:19
26 concerned as P34's speech seemed delayed. P34
27 began to show a weakness in his left arm and was
28 dropping things. P34 was referred to a
29 physiotherapist at the Royal Victoria Hospital in and

1 around 1996 and it was suggested that he might have a
2 learning disability. At this stage, we were advised
3 that it was unlikely P34 would be able to attend a
4 mainstream school. I recall coming out of that
5 appointment crying. It was a shock.

10:19

6 P34 would have been overly social and active. He
7 did seem to prefer the company of adults."

8
9
10 Then, ^{P34's mother} from paragraphs seven to 12 you describe
11 P34's schooling and the challenges that he faced
12 with that and at paragraph 10, you then go on to say
13 that P34 was diagnosed with autism when he was
14 around 10 years old.

10:19

15
16 So I am going to, having summarised those, just pick up
17 the reading at paragraph 13 across the page, where you
18 say:

10:20

19
20 "In and around 2003, P34 attended the Children and
21 Adolescents Clinic at Massereene Hospital in Antrim for
22 assessment. I agreed that a referral would be made for
23 P34 to the Learning Disability Team as an
24 outpatient of Dr. H50. It turned out that, instead,
25 P34 was placed under the care of Dr. H40 at
26 Whiteabbey. Dr. H40 doubted the educational
27 psychologist assessment of P34 as autistic because
28 he felt P34 was too sociable. Dr. H40 felt P34
29 just had a learning disability and was a bit

10:20

10:20

1 hyperactive. He considered the most suitable treatment
2 was via medication. I cannot recall whether P34
3 was on Ritalin at that time. In any event I think
4 Dr. H40 prescribed either Risperidone or Seroquel.

10:21

6 I recall Dr. H40 advising that if we got P34 into
7 MAH for assessment for a couple of weeks then he could
8 get back to school. This led to P34's first
9 admission to MAH in and around March 2005. When

10 P34 went into MAH he was age had 11 years old.

10:21

11 P34 was placed in Conicar, which was a children's
12 ward. The Ward Manager was H122 who I thought was a
13 lovely man. I remember Dr. H40 told us that P34
14 had the "creme de la creme" of staff. I did genuinely
15 think the admission would be for a couple of weeks.

10:21

16 I recall the admission day and I attended with
17 P34's Daddy and his sister P34's sister I do not
18 remember signing any documents or having any formal
19 introductions but I do remember a Staff Nurse named
20 H551 who was very good with P34 and was like a
21 motherly figure to him.

10:21

23 During this admission, P34 would have returned home
24 from Friday to Sunday. A teacher also went to MAH from
25 Riverside school in Antrim to assist with education.

10:22

26 I recall a report provided by this teacher was the
27 first educational report that was positive. The
28 teacher would have taken P34 to the library. There
29 was also a behaviour nurse called H588 who was very

1 good and pro-active. P34 seemed happy at that
2 time. I would visit him and at this point I had no
3 major concerns.

4 When P34 was admitted to MAH in 2005 he had mild to
5 moderate learning difficulties, Attention Deficit
6 Hyperactivity Disorder and Autism Spectrum Disorder.

10:22

7 I know that MAH now say that P34 has severe
8 learning difficulties, which I believe is due to his
9 poor treatment over the years, and bipolar disorder.
10 However, I dispute this bipolar diagnosis.

10:22

11
12 P34 has also been diagnosed with a heart condition,
13 Long QT Syndrome 7. I do not know if this was
14 something P34 has had since birth, it was not
15 diagnosed until some years later or if the medication
16 P34 has been continually prescribed has induced
17 this.

10:23

18
19 The consultant treating P34 in MAH was Dr. H49. As
20 a consultant, I found her hard to communicate with.
21 She would not provide much information or updates on
22 the assessment process.

10:23

23
24 P34 was aged 12 years when he was discharged to
25 home. He returned to Hillcroft School.

10:23

26 Upon discharge, P34 came home for about 18 months
27 and during this time, I believe he was on some other
28 medication. We had gone away as a family to Donegal
29 that summer and P34 was not great. I could see

1 P34 declining and he would have been bed-wetting.
2 He had put on weight and would have presented as
3 unpredictable. I felt this was medication-related as
4 it was not a presentation P34 had displayed in the
5 past.

10:23

6
7 In or around November 2007, close to P34's
8 birthday, P34's Daddy had taken him to a football
9 match and P34 had become a bit agitated at the
10 football. When P34 returned home, he lost control. 10:24
11 He pulled curtains down, knocked pictures off the wall
12 and kicked out at his sister. This was never before
13 P34's presentation. I telephoned MAH to say I
14 needed help. They said that they could not do anything
15 as he had been discharged. I then telephoned the 10:24
16 out-of-hours social worker who eventually came out to
17 the house. An out-of-hours doctor attend and gave
18 P34 more medication, which was again a
19 benzodiazepine drug. This made things worse again.
20 Contact was then made with Dr. H50 who said that there 10:24
21 were no beds in MAH and suggested an appointment.
22 Eventually, MAH conceded that P34 needed emergency
23 admission. Police were in attendance. P34 was
24 taken by ambulance and I accompanied P34 in the
25 ambulance with him. There was no need for restraint, 10:24
26 P34 went like a lamb. I did not want this by felt
27 I had no choice.

28
29 P34 was admitted at about 3:00 a.m. to Cranfield 1,

1 which is a male ward. It was explained that this was
2 because there were no beds available in the children's
3 ward. I was unaware of the arrangements that were made
4 for P34 in recognition that he was only fourteens
5 years old and being placed on an adult ward. I do 10:25
6 believe that Dr. H40 was of the opinion P34
7 required one-to-one care whilst in the adult ward and
8 this was provided.

9
10 P34 was formally detained under the Mental Health 10:25
11 Order by a doctor at MAH. This was not explained to me
12 at the time but I did understand that this meant
13 P34 could not leave MAH. I was not given any
14 literature or brochures when P34 was admitted or
15 detained. No-one ever took the time to explain the 10:25
16 process of admission or detention to me. I thought it
17 was for P34's own protection and I did not
18 understand that it gave powers to MAH. I would have
19 visited P34 with family about three or fours times
20 a week and at weekends when he was in the adult ward. 10:26

21
22 After about three or four weeks, a bed was available in
23 Mallow. Mallow was a children's ward and I felt this
24 was an appropriate transfer. Although P34 was
25 moved between wards, I am unaware of any risk 10:26
26 assessments related to these moves.

27
28 There was a different ward manager for Mallow at this
29 time called H397. Whilst P34 was under his care,

1 for reasons I am unaware of, P34's previous
2 behaviour nurse, H588, was unable to work with him.
3 I found this unfortunate as P34 had worked very
4 well with her in the past.

5
6 My family were never really allowed onto the ward.
7 When we visited P34 during his time on Mallow, we
8 could see he was deteriorating and I understand there
9 was complaints about his behaviour. I recall an
10 incident in and around 2008 about which I made a 10:26
11 statement to the police on the 10th of February 2009
12 which I attach at Exhibit 3 and the contents of which I
13 wish to adopt as part of my evidence to the Inquiry.
14 A file was sent to the PPS about that incident but I
15 later received a letter to advise there would be no 10:27
16 prosecution. A multidisciplinary team meeting took
17 place about this incident involving the police.
18 However I was not invited to this. I am unsure if H578
19 was sacked or otherwise left. However, I did not see
20 him again after this. 10:27

21
22 I recall a one-off children's party in MAH around 2008
23 or 2009. I have a fond memory of P34 recognising
24 the staff member H600 that was in disguise as Santa for
25 the children. I also recall P34 running back and 10:27
26 forth towards H578 at this party and he was laughing.
27 Reading the situation now, I think P34 was
28 indicating that H578 could not harm him whilst his
29 family was present.

1
2 I had many concerns regarding Mallow. There was
3 another incident when there was insufficient staff due
4 to an emergency. As a result, a nurse locked P34
5 in the bathroom on his own. I felt the management of 10:28
6 Mallow was not up to scratch. I recall being told at
7 the time that the staff member involved was put on
8 supervision.
9

10 In 2010, P34 was transferred to the Iveagh Centre. 10:28
11 Ivy opened on 26th March 2010 as a specialist facility
12 for the diagnosis of children with mental health issues
13 and disabilities. Mallow had closed and P34 was
14 transferred to Ivy when it opened. I cannot recall
15 being shown any risk assessment for P34's transfer 10:28
16 to Ivy or any transitioning work being done with him.
17 There was no gradual transition. It was just a matter
18 of moving the children to Ivy to get them away from Six
19 Mile which was a forensic ward. That is what the
20 manager at the time told me. 10:28
21

22 The same MAH management was transferred from Mallow to
23 Ivy including H397. I visited P34 several times a
24 week and did his washing. P34 had started to go to
25 Glenn Craig at this time. Glenn Craig was a daycare 10:29
26 education centre. P34 would also have come
27 periodically at this time.
28

29 P34's behaviour deteriorate had even further at

1 Ivy. Environment is so important for well-being and I
2 felt Ivy was unsuitable. Ivy is in an urban setting as
3 opposed to P34's home and MAH. There was nowhere
4 to take P34 for a walk. It became harder and
5 harder to take P34 home. I do not feel that Ivy
6 met P34's needs.

10:29

7
8 On the 12th July 2011, there was rioting around Ivy.
9 I saw the news reports on television and I was
10 extremely worried about P34 I telephoned Mencap
11 and The Stephen Nolan Show as I was concerned that Ivy
12 was not a safe environment. P34 was just shy of
13 his 18th birthday by this stage and would not be able
14 to stay in Ivy once he was 18 years old. I asked
15 Dr. H40 could they transfer P34 back to MAH for
16 assessment and treatment. Dr. H40 agreed for P34
17 to be moved back to Cranfield 1 before his 18th
18 birthday with support of extra staff due to him being
19 in an adult ward.

10:29

10:29

20
21 I understood this was to be one-to-one care for P34
22 due to the circumstances. I was not happy with P34
23 remaining at Ivy at this time and I was happier with
24 the move and assurances in relation to Cranfield.

10:30

25
26 Dr. H40 lifted the detention on P34 when he was
27 18 years old and so P34 became a voluntary patient.
28 P34 started to improve and then he was moved to
29 another ward called Killead in about 2012. P34 had

10:30

1 been assessed and treated in Cranfield 1 and
2 I understood he was being moved to Killead in
3 preparation for discharge resettlement. P34's time
4 in Killead was disastrous. Killead was an open plan
5 ward with older men just sitting about. P34's
6 behaviour deteriorated and he tried to run out of the
7 ward any opportunity he had. I feel he was trying to
8 escape this environment, which he was unhappy in as
9 there was no stimulation.

10:30

10
11 Whilst P34 was in Killead he was under the
12 consultant, Dr. H49. After approximately two months of
13 P34 being in Killead, I approached Dr. H49 about my
14 concerns regarding P34's environment and behaviour.
15 However, I felt she was dismissive and not very
16 helpful.

10:31

17
18 I then went, with the support of P34's sister,
19 P34's sister to see Dr. H40, P34's previous consultant
20 from Cranfield. I raised the same concerns with him
21 and requested P34 be moved back to Cranfield which
22 Dr. H40 agreed to. P34 had deteriorated to the
23 extent that when he was moved back to Cranfield 1 in
24 mid 2012 he would not get out of bed.

10:31

25
26 I cannot recall seeing any risk assessments or plans
27 related to P34's moves between Ivy, Cranfield 1 and
28 Killead, nor was I aware of P34 being prepared for
29 the differences between those wards and his life on the

10:31

wards. My family trusted that staff in MAH knew best and we are now saddened that our trust was betrayed.

In 2013, there was an incident in relation to an outing to Glenn Craig. P34 had not slept and had fallen asleep at around 6 am. Despite this, the Cranfield staff got him up an hour later to send him in a taxi to Glenn Craig. After he had left the staff realised that P34 had not been given his medication so he had to be returned so he could take it. During the journey P34 felt sick and had to stop at the Culloden Hotel where he vomited. I understand P34 had a very difficult day at Glenn Craig and was agitated and hitting out. P34 was collected again by taxi to go back to MAH and his level of agitation in the taxi resulted in him being taken to Holywood Police Station. On arrival, the police surrounded the car and P34 was struck on the arm with a baton. The Glenn Craig staff came on the scene and told the police to back off. I spoke to the sergeant in Holywood about my upset and dissatisfaction in relation to this incident and was advised that this could be reported by the Police Ombudsman. I did not follow this through as I was not advised on the process of how to do so and I was extremely stressed about the matter.

I do not feel that it was appropriate for MAH to send P34 that day to Glenn Craig due to his lack of sleep and the delay in administering his medication.

1 I believe some one should have undertaken a risk
2 assessment on whether P34 should go to Glenn Craig.
3 The bottom line is P34 should never have been taken
4 out of bed that morning to go anywhere.

10:33

6 I understand the day after this incident there was a
7 meeting and a Glenn Craig staff member attended along
8 with the consultant Dr. H40, Social Worker 2 and
9 another member of MAH management. I do not believe
10 this incident was taken seriously or dealt with
11 appropriately.

10:33

13 Around this same period of time, P34 was not happy
14 and was completely unsettled. I was going up three to
15 four times a week to visit him in MAH. P34 was not
16 getting out of bed on the ward until the evening time.
17 I think this suited the staff as it was one patient
18 less to care and support.

10:34

20 There was also a period when P34 was not sleeping.
21 He was very restless. His medication was being
22 adjusted all the time to try and deal with it and I am
23 concerned about the effect of that on his brain. It
24 now distresses me, with knowing what I know, that
25 P34's unhappiness and unsettled behaviour may have
26 been indicative of him being abused.

10:34

10:34

28 P34 did not have self-injurious or self-harming
29 behaviour when he was at home, nor did he show

1 aggression towards others. He was always happy when
2 people were happy around him. I believe P34
3 developed this aggression whilst in MAH.
4 It was around this time in 2013 when I just felt
5 something was not right in MAH. I do not know what was 10:34
6 making me feel that way. I was afraid and it was
7 starting to really impact my mental health. P34
8 would have told me certain staff members were bad.
9 I would try and reassure him and I would tell him I was
10 going to speak to the doctor about this but then he 10:35
11 would say no, they were not bad. I believe P34 was
12 afraid of the consequences.

13
14 During MDTMs, P34's unsettled behaviours were being
15 report by nursing staff on the ward and subsequently 10:35
16 P34's medication was being changed regularly. It
17 is my belief that some of the nursing staff involved in
18 reporting P34's behaviour at these MDTMs were
19 alleging abusing P34 based on the names and
20 allegations P34 has since communicated to me and 10:35
21 his Daddy.

22
23 I was also concerned about the overuse of PRN. My
24 understanding was that PRN medication should have been
25 used as a last resort, not as an easy and convenient 10:35
26 intervention. I noticed there to be a pattern of
27 increased use of PRN associated with a certain core of
28 staff. I did raise this at one of the MDTMs.
29 I remember P34 was placed in the seclusion room on

1 numerous occasions. I did not know what it was
2 initially. At this time I did not even see P34's
3 bedroom in Cranfield, let alone the seclusion room.
4 MAH staff never really described what or why the
5 seclusion room was used. I was just told it was for 10:36
6 deescalation. I was never provided with any procedures
7 or guidance governing its use. In my head, and because
8 MAH staff had reassured me that P34 was fine and
9 that staff would have been outside the door, I had a
10 false sense that it would have been a nice room. 10:36

11
12 I recall that on one occasion during a telephone call
13 to the ward, I asked was P34 back on the ward and
14 was told that he was still in seclusion and was banging
15 on the door. This was very distressing to hear. I was 10:36
16 led to believe that this was an appropriate facility.
17 However, I now feel that some staff used it to punish
18 patients or for their own convenience.

19
20 In early 2018 I recall visiting MAH and hearing a lot 10:37
21 of hammering. I asked what it was and I was informed
22 MAH were doing the seclusion room up. I understand the
23 seclusion room looked much different following this
24 renovation.

25 10:37
26 Whilst in MAH, P34's physical appearance was very
27 poor on a lot of occasions. Sometimes P34 would
28 come out wearing other people's clothes and shoes.
29 I recall P34's clothing being ripped, specifically

1 around the neck, and when I questioned this, I was told
2 that it was related to the washing machine, although I
3 did a lot of P34's washing at home, or he was
4 ripping his clothes himself. I found this astonishing
5 as this was never a behaviour P34 displayed at 10:37
6 home. On occasions, P34 would also be presented
7 wearing clothing inside out.

8
9 P34 has always required support with every aspect
10 of his personal care. I recall during a family visit, 10:37
11 I brought buns to the Cosy Corner. Whilst eating them,
12 P34's Daddy noticed had and was disgusted at the
13 dirt in his nails. This appeared to be faeces. We
14 returned right away to the ward and raised this
15 discontent with a nurse called H591. I was very upset 10:38
16 at her dismissive manner and when I mentioned that I
17 was aware there had been several outbreaks of
18 Norovirus, that P34 had been a victim to, she
19 became very defensive. The member of staff that was
20 supposedly caring for P34 that day was called H592. 10:38
21 He was very curt with myself and my husband for around
22 one year after we raised this issue. After this
23 incident, I always carried a nail brush and scissors in
24 my bag to cut P34's nails."

25
26 And then if you turn over to paragraph 58.

27
28 "P34 was happy when he came home for visits.
29 However, his motivation at that time was not great.

1 I would have arranged to take P34 out in the car a
2 short walk or for a visit to family to try and lift his
3 mood. As far as I am aware, at this time around 2014,
4 no activities were arranged by MAH for P34
5 Looking back now, MAH generally were not concerned with 10:39
6 the physical health of P34

7
8 Another issue of concern was P34's teeth and dental
9 hygiene. P34 had developed a bad infection in his
10 tooth. It was obvious to me that something was wrong 10:39
11 as he had a very swollen face at his jaw. P34 must
12 have been in a lot of pain. I asked the staff to
13 arrange an appointment with the dentist and P34 was
14 prescribed an antibiotic.

15 10:39
16 Right up to the present day, brushing his teeth has
17 remained an issue. This was raised all the time at
18 visits as it was clear P34 had not been getting
19 support to brush his teeth. I brought a toothbrush and
20 toothpaste with me to visits. Throughout his time at 10:39
21 MAH, P34 had various dental procedures including
22 two extractions and seven new fillings in May 2023,
23 seven fillings in July 2021, as well as having other
24 teeth extracted on other occasions. I recall another
25 time during a visit when I spotted black in P34's 10:40
26 teeth. That was decay and had to be removed. It was
27 very clear to me that MAH staff were not regularly
28 brushing P34's teeth. This was the level of basic
29 care that was lacking.

1
2 Somewhere around 2021 when MAH began doing physical
3 health checks on the patients, I was informed that
4 P34 had a small swelling in one of his genitals.
5 This concerned me. However, I was reassured by the 10:40
6 Deputy Ward Manager, H415, that it would be monitored.
7 During monitoring in 2022, it was thought that this
8 swelling had become more evident. As a result, P34
9 was seen by Dr. H242 who is a GP with the Belfast
10 Health and Social Care Trust. Doctor H242 referred 10:40
11 P34 for an ultrasound in Antrim Area Hospital where
12 it was concluded that P34 had what was known as a
13 hydrocele. Based on a patient information leaflet sent
14 to my daughter P34's sister in an e-mail from Dr. H242 that
15 I have attached at Exhibit 5, hydroceles are generally 10:41
16 uncommon and one of the potential causes can be an
17 injury.

18
19 Some staff had an inappropriate way of speaking with
20 P34 if he did something jokingly like touch a 10:41
21 staff member on the bottom. P34 would have
22 exhibited this behaviour for a while, but rather than
23 dealing with this in a mature and professional fashion,
24 staff would have said: "Don't touch what you can't
25 hold in your hand". I felt this was a strange almost 10:41
26 sexualised way to speak to a person who did not
27 appreciate or understand this kind of language.

28
29 I clearly recollect an upsetting conversation with a

1 concerned staff member during a visit with P34 in
2 early 2023. P34 had requested a glass of water and
3 the staff member working with him promptly responded to
4 get it for him. When the male staff member returned
5 with the water, he seemed upset and informed me that 10:42
6 when he asked his colleague for P34's water through
7 the locked door in the pod, a female member of staff
8 had said to him: "They don't always get what they
9 want." He then said to me: "Water doesn't cost
10 anything, and none of us will ever know when we need 10:42
11 someone to care for us."
12

13 He was one of the few very compassionate and caring
14 members of staff I have come across in MAH. I am not
15 aware if my presence was known by the female staff 10:42
16 member but this was very disturbing to hear and it led
17 me to question if P34 was refused something as
18 basic as a glass of water, what other ways was he being
19 neglected. I always felt a sense of sadness and
20 helplessness when leaving P34 after a visit and 10:42
21 felt that I was letting him down by leaving him there.
22

23 Over the years P34 has had access to several
24 mobile phones which I had purchased for him to allow
25 him to call and speak to his Daddy and me each evening 10:43
26 as part of his nightly routine. However, on numerous
27 occasions this did not happen and when I questioned
28 staff on why P34 had not called, I was generally
29 told that the phone needed charged or the phone charger

1 could not be found. As a result of this, P34
2 missed out on his family telephone calls which were
3 extremely important to him to get reassurance from his
4 Daddy and me.

5
6 There were other items we bought for P34 over the
7 years such as a CD player, radio, Wii, Play Station,
8 and expensive aftershaves which went missing, or you
9 would smell the aftershave on him once or twice and
10 then it would be gone. Staff also never engaged with
11 P34 in using any of these items and when we asked
12 where they were, we were told they were broken or staff
13 said they were not sure where they went, but we would
14 never have seen them again. This is also why I would
15 only leave in what P34 needed and when he needed it
16 as I did not trust the staff.

17
18 P34 stayed in Cranfield 1 until June 2017 when he
19 was resettled in a residential facility providing
20 specialist services and which is operated by the Priory
21 Group. During this resettlement, H593, who was a
22 behavioural specialist in MAH, worked intensely with
23 P34 H593 had worked previously for several years
24 with P34 initially as a Staff Nurse and then in
25 the behaviour team. She had a really positive impact
26 on him and he was thriving with her input. H593 would
27 have taken P34 out for dinner to forest walks, and
28 she brought him to our family home every week for
29 lunch. H593 was a Lifeline to P34 in MAH.

1
2 In September 2017, when P34 was beginning to settle
3 in the resettlement facility, I received a telephone
4 call from H411 within the safeguarding team at MAH.
5 H411 said that they were investigating an incident 10:45
6 involving P34 in a swimming pool four or five years
7 previously. No details were provided and five months
8 later, H411 called back to say there was nothing to
9 this. I do not know what the alleged incident had been
10 or how P34 was said to be involved. I found the 10:45
11 whole matter very concerning.
12

13 On the week leading up to Christmas 2017 P34 was
14 physically unwell with cold and flu-like symptoms. Bu
15 the middle of the week, Dr. H599 had stopped P34's 10:45
16 Clozapine medication immediately, due to three red flag
17 blood results that showed he had abnormally low levels
18 of white blood cells, Neutropenia. I was only made
19 aware of his cessation of Clozapine 48 hours later by a
20 support worker in the resettlement facility. Dr. H599 10:45
21 had not informed me of this.
22

23 We had planned to have Christmas dinner at P34's
24 sister house with extended family. However, in the
25 early hours of Christmas morning, P34 was admitted 10:46
26 back to MAH. His cold and flu-like symptoms had got
27 worse and I was informed that P34 was presenting
28 with strange behaviours, for example, trying to step
29 over walls that were not there. In hindsight, this

1 sounds like P34 was delirious, which in my view may
2 have been the result of abrupt medication stoppage or
3 underlying infection as a result of his low levels of
4 white blood cells.

5
6 P34 was in MAH for about five days before a doctor
7 decided to get P34 an emergency admission to Antrim
8 Area Hospital due to his physical health deterioration.
9 All of P34's medications were then stopped. He had
10 developed pneumonia and flu. I remember P34 was
11 moved to the flu ward. My daughter, P34's sister and her
12 husband visited P34 there and she was told that he
13 may need to go to ICU to let his body recover.

14 Thankfully, he started to respond to treatment and this
15 was not required. I feel that if P34 had have been
16 taken to Antrim Hospital on Christmas morning rather
17 than MAH, he may not have gone on to develop pneumonia
18 and flu.

19
20 I remember this time vividly as P34 described his
21 time in Antrim Area Hospital as the time "the sun came
22 out". To this day, he still recollects being in Antrim
23 Hospital when "the sun came out", I believe this is
24 where he felt safe.

25
26 On discharge from Antrim Hospital P34 returned to
27 MAH for several days before moving back to his
28 resettlement facility. He was there only for a short
29 period before he had to return to MAH due to what I can

1 only recollect as being withdrawal side effects from
2 the abrupt stopping of medication. On his return, he
3 was initially placed in Cranfield 1 but subsequently
4 moved to PICU a short time later. When P34 moved
5 to PICU, I felt this was a positive move as I was 10:47
6 informed by MAH that this ward had a smaller number of
7 patients and was for more Intensive Care. I believed
8 this would make his return to the resettlement facility
9 happen more promptly. I was not aware at this time
10 that there had been abuse in Cranfield or PICU. 10:48
11 During P34's time in PICU, H593 became involved
12 with him again in terms of behavioural support. Things
13 started to look more positive with her input until
14 early Autumn when I began noticing that a lot of
15 regular staff were no longer around and agency staff 10:48
16 were starting to appear. I suspected this was having a
17 detrimental effect on P34's behaviour at the time.
18 I believe it was around this time that I became aware
19 of the alleged abuse in PICU prior to P34 being
20 there. 10:48

21
22 In subsequent years I have also become aware that
23 P34 had been started on Haloperidol in August 2018
24 which was increased to the maximum dose of 20mg by
25 November 2018. I feel the introduction of this 10:48
26 anti-psychotic medication may have played a key role in
27 P34's mental health deterioration and that it still
28 continues to do so.
29

1 P34 had remained almost entirely in MAH from
2 December 2017 to March 2019. Although P34 was in
3 MAH from December 2017 he still had a placement in the
4 resettlement facility which was being paid for. It is
5 my understanding that staff from the resettlement
6 facility were therefore supposed to come to MAH and
7 work with P34. However, they did not come
8 frequently enough or for long enough periods and did
9 not work closely enough with the staff who were caring
10 for P34 in MAH at the time. Instead, they seemed
11 to come to MAH only on a rare occasion. This was not
12 just my own perception as staff in MAH also indicated
13 that this was the case to me and at least one Staff
14 Nurse expressed sympathy to me about this.

10:49

10:49

15
16 The failure to undertake sufficient work with P34
17 in advance by the resettlement facility staff was one
18 of the key reasons the placement ultimately failed.

10:49

19
20 By March 2019, a locum consultant pushed for P34 to
21 go back to the resettlement facility on the basis that
22 if the placement was not again attempted at that stage
23 it would never happen and the family would never know
24 if it would have worked. An attempt was therefore made
25 at that stage to try the placement again.

10:50

10:50

26
27 When P34 went back to the resettlement facility in
28 2019, the behaviour team from MAH, who continued to
29 engage with him for a while, soon advised that the

1 placement was not working. I believe that a key reason
2 for this was a lack of familiarity between P34 and
3 the staff in the resettlement facility. I think the
4 fact that staff for the resettlement placement had not
5 been coming to P34 and working with him alongside 10:50
6 the staff in MAH regularly over an extended, prior to
7 the placement beginning, undermined the possibility
8 that the placement would succeed. P34 ended up
9 paying almost £500 a month out of his ESA for the
10 resettlement placement during the period December 2017 10:51
11 to March 2019 and as ESA was his only benefit or
12 income, this left him only £20 per week for anything
13 else.

14
15 In and around March 2019 the proposed placement ended 10:51
16 due to a deterioration in P34's mental health and
17 this required a reassessment.

18
19 I do not feel that P34 had been properly prepared
20 for his re-transition from MAH to the resettlement 10:51
21 facility. Also, there were other issues with the
22 placement. By way of example, when P34 returned to
23 the resettlement facility, he was sharing the unit with
24 a female who self-harmed by banging her head off the
25 walls, which I believe was distressing for P34 to 10:51
26 witness. When I spoke with management about the
27 incompatibility of P34 and this other female
28 resident, I was simply told that they needed to fill
29 the beds.

1
2 P34 was readmitted to MAH where he remained until
3 May 2023 when his transition to supported living in the
4 community commenced."

5
6 And then picking up paragraph 90, you say:

7
8 "In January 2022, I initially contacted the ward to
9 advise that I was on my way to visit P34 However,
10 the staff member informed me that P34 had come from 10:52
11 his own living space which was referred to as a "pod"
12 and was now in the day space in which he was refusing
13 to leave to return to his pod. The staff member told
14 me that she did not think our visit was advisable as
15 P34 was unsettled. I informed her that I believe 10:52
16 the visit from his family would settle him down so we
17 proceeded to visit and as I suspected, seeing his Daddy
18 and I helped P34 to settle. Whilst the visit was a
19 good one for P34 it was extremely difficult for
20 his Daddy and I as it was the first time we had ever 10:52
21 seen P34's living condition and it gave rise to
22 significant concerns about P34's care.

23
24 Following the visit that day we both returned to our
25 car in silence and cried at the thought of our son 10:53
26 being confined to those horrible conditions for so
27 long.

28
29 The environment in which P34 lived in

1 MAH was a separate pod. This was arranged when P34
2 had been in Cranfield 1. Staff said that several
3 safeguarding issues had been raised against P34
4 because he was getting in people's faces and they said
5 he had to be moved to the pod where he could regulate 10:53
6 himself. At that time, the staff had painted a picture
7 of the pod as an attractive space that would be his own
8 but it would also allow him to go up and down to the
9 day space when he wanted. My daughter, P34's sister has
10 also provided a statement to the Inquiry and will be 10:53
11 providing further information on the pod.
12

13 I believe P34 spent most of his time isolated from
14 other residents in the pod and seemed very frustrated
15 as a result. It was not positive. P34 was behind 10:53
16 locked doors. Although P34 had a small TV in a box
17 in the pod, when we visited the TV was off, nor was
18 there any music on. There was no pillow on his bed.
19 P34 had also thrown his clothes and slippers up to
20 where there was a pitch in the ceiling and no-one had 10:54
21 taken them down. The area was depressing. The walls
22 were blank and colourless. It was grubby and never
23 smelled clean. It appeared more like solitary
24 confinement than a living environment for someone with
25 a proper quality of life. 10:54
26

27 Prior to us being able to visit P34 in the pod, we
28 would have had our visits in the Cranfield visitors
29 room. The staff would not bring P34 through the

1 ward. Instead they would have walked him right around
2 the outside of the building no matter what the weather
3 was like and they would have said the ward was
4 unsettled, which is why they did this, but I did not
5 believe them. I believe this was simply to prevent 10:54
6 P34 from gaining access to the ward. P34 would
7 have got anxious at the end of our visits as he knew he
8 had to go back into the pod again.

9
10 I recall times myself and my husband would have had to 10:54
11 wait a long time to see P34 up to 30 minutes on
12 occasions. I also recall being left waiting outside in
13 the rain to gain entry to the pod once we were
14 permitted to have the visits there. I believe these
15 delays were possibly due to staff getting P34 10:55
16 cleaned and dressed appropriately. On one occasion, a
17 female staff member informed me during a visit that she
18 had seen P34 in a bad state of hygiene that
19 morning. He was not in her care at the time. However,
20 she went out of her way to get him showered, shaved and 10:55
21 changed. She wanted to do this as she did not like to
22 see P34 in that state. This was positive to hear
23 and I was so grateful to see a member of staff have a
24 genuine respect for P34 This was not common.

25 10:55
26 In comparison, on another occasion whilst we were
27 visiting, P34 was soaking right down to his socks
28 in urine. The staff member working with him just
29 changed his clothes without even washing or showering

1 him. I had to insist that he was taken for a shower
2 which they then did in the end.

3
4 It is very important for P34 to be familiar with
5 those who are caring for him. During a visit in 10:56
6 January 2022 we did not recognise the member of staff
7 who was with P34 throughout the visit. I asked
8 P34 his name and he said he did not know. The
9 staff member did not introduce himself to us and did
10 not speak a word to us or P34 except when P34 10:56
11 got excited and ran towards him. At this point the
12 staff member said: "Get away", as though he was
13 frightened. This reaction made me feel very sad. He
14 responded to my son as if he was a danger to him. I do
15 not think it was appropriate for P34 to be cared 10:56
16 for by someone unfamiliar to him."

17
18 At paragraph 99, you say:

19
20 "In June 2020 the prospect of resettlement had been 10:56
21 raised by the Northern Health and Social Care Trust
22 Resettlement Social Worker for P34 and a placement
23 was identified with Inspire in Mallusk. No timescales
24 were confirmed and progress seemed very slow. I do
25 recall the Inspire Director showing me around Mallusk 10:57
26 in June 2020 just at the height of the pandemic. On
27 13th August 2021, the Resettlement Co-Ordinator
28 telephoned me to update me on Inspire's difficulties
29 with staff recruitment and delay with the Inreach

1 services. This was very disappointing.

2
3 On the 22nd of September 2021, the resettlement
4 coordinator telephoned again about the ongoing
5 recruitment issues. I expressed concern about P34 10:57
6 remaining in MAH due to the ongoing Covid restrictions
7 which were limiting our visits and access to him and
8 the fact MAH was becoming heavily reliant on agency
9 staff.

10
11 Also, most importantly, P34 was still living in the 10:57
12 environment that he had been allegedly abused in.

13
14 On 22nd October 2021, given the absence of any
15 confirmed dated or progress for P34's resettlement 10:57
16 from MAH, I issued judicial review proceedings on
17 behalf of P34 against The Northern Trust.

18
19 Throughout the rest of 2021 the resettlement
20 co-ordinator would update me from time to time on 10:58
21 recruitment issues in the proposed placement. The
22 judicial review proceedings subsequently resolved by
23 agreement on 8th March 2022 which was based on
24 transition work for P34's resettlement to Mallusk
25 starting on 31st October 2022 and expected to take 10:58
26 between six and 12 weeks.

27
28 At the beginning of 2022, my daughter, P34's sister and I
29 raised concerns about the plan for P34's care and

1 resettlement. We asked what services would be
2 supporting P34 during his transition as there was
3 currently no occupational therapist, behavioural
4 support or physiotherapy allocated. I advised that
5 P34 had been badly abused and I felt it was
6 important for him to have access to a psychologist.
7 The response I got from P34's consultant at that
8 time, Dr. H253, was that she was not in post at the
9 time of the allege had abuse. We had to insist for
10 over a year for support provisions to be put in place
11 for P34 and even when they were, they were at a
12 minimal.

10:58

10:58

13
14 I recall in March 2023 the RQIA did an unannounced
15 visit at MAH. I was only aware of this at the time as
16 I had been advised by another patient's mother.

10:59

17
18 Following this, I contacted the RQIA and asked if they
19 saw P34's living conditions but I was advised they
20 were following the same patients they had looked at the
21 previous July 2022 so they did not have P34 on
22 their radar. The woman from RQIA did advise me that
23 they had actually been at the door of the pod.
24 However, they were told the patient currently had
25 visitors. She said that the RQIA representative asked
26 for a message to be relayed to the family to let them
27 know they had been there and if we wanted to contact
28 them, we could. This was never relayed to me by MAH
29 staff.

10:59

10:59

1
2 During the same telephone call, I begged that RQIA
3 revisit and specifically go and see the pod.
4 To my surprise, RQIA did attend again just two days
5 later. The following day, we had a planned MDTM and my 11:00
6 family had the support of Gerry Kelly MLA in
7 attendance. P34 was subsequently moved from the
8 pod to the main Cranfield 2 ward the following week.
9 I believe the MLA presence, along with the visit from
10 RQIA, may have influenced this move as we and family 11:00
11 had begged for P34 to be moved from the pod for
12 over a year.

13
14 P34 moved to Mallusk on the 1st June 2023. During
15 the month of May, when his transition began, P34 11:00
16 would have visited Mallusk for anywhere between 30
17 minutes to two hours. This was not a daily occurrence
18 until later in the month.

19
20 On the 1st June 2023, P34 was taken down to Mallusk 11:00
21 with a member of staff from MAH that he liked. P34
22 was asked if wanted to stay the night and he did. He
23 also then stayed again the following night. It was
24 unfortunate when my husband and I went to visit on the
25 third day P34 was very unsettled and wanted to go 11:00
26 back to MAH. This request did not happen. Although I
27 wanted P34 out of MAH, I feel the way his
28 resettlement has been handled is all wrong. It should
29 have been at P34's pace, which was promised to us

1 as family by the Northern Trust Resettlement Team.
2 However, this has not been the case.

3
4 Although MAH have said what P34 was fit for
5 discharge when his transition began, we, as a family, 11:01
6 feel that his presentation presentation at this stage
7 was one of the worst he has displayed. We are putting
8 this mainly down to the multitude of medication he has
9 been on. For example, he is currently prescribed two
10 anti-psychotics and two mood stabilisers, amongst other 11:01
11 medications, to counteract the side effects of these.
12 P34 has spent three years in seclusion in a pod not
13 fit for purpose.

14
15 There has been a pattern of incidents which arises from 11:01
16 P34's medication and I do not accept that proper
17 monitoring of P34's medication ever occurred whilst
18 at MAH. I was not aware of the amount of medication
19 P34 was on and I do feel if he had been resettled
20 in mid 2018 when he was presenting much more settled, 11:02
21 he would have flourished at that stage.

22
23 Although the resettlement to Mallusk is in its early
24 days, we as family are relieved he is now out of MAH
25 and we are hopeful that with this change of environment 11:02
26 and with good support staff working with him, he will
27 flourish.

28
29 My daughter, P34's sister and I had sight of a Northern

1 Trust Care Plan and Positive Behaviour Support Plan
2 around May 2023 and I attach these documents at Exhibit
3 6. They were provided to us for review by members of
4 The Northern Trust Resettlement Team. These plans were
5 based on what was used in MAH. It was the first we as 11:02
6 family had ever seen any care or behavioural plans for
7 P34 My daughter, P34's sister and I have had to go
8 through these documents and make extensive changes to
9 update inaccuracies and outdated information. I have
10 attached our edited versions at Exhibit 7." 11:02

11
12 And at paragraph 111 you say:

13
14 "P34 has been let down at every stage of what
15 should have been assessment, treatment, and care, no 11:03
16 less than the professional standard of care for a
17 vulnerable person within a specialist hospital, along
18 with full compliance to the policies and procedures
19 that should have ensured that standard was met.
20 The Belfast Trust has apologised to all patients and 11:03
21 their families who have been involved in the
22 allegations of abuse and mismanagement at MAH. The
23 Belfast Trust and the Northern Trust have, however,
24 continued to let P34 down over the arrangements for
25 his resettlement from MAH. He was left in MAH where a 11:03
26 culture of abuse was allowed to develop and where he
27 had been abused. It took a judicial review to expedite
28 his resettlement.
29

1 The lack of meaningful preparation to ensure a
2 successful transfer to a suitable facility is an
3 important issue as the consequences of a placement
4 failure were not only serious for P34 in terms of
5 his health and an unnecessarily prolonged stay in MAH 11:04
6 but it also affects the likelihood of a successful
7 transfer to an alternative facility.

8
9 I feel like some therapeutic support or intervention
10 should be provided to patients who have been abused. 11:04
11 In my view, P34 requires an independent assessment
12 as to the impact of the abuse on him and that this
13 should be funded by the Belfast Trust.

14
15 P34 has been identified as being abused from day 1. 11:04
16 MAH should have had Psychology involved and he never
17 should been secluded in the pod. I feel as though
18 P34 was punished a second time and was at the mercy
19 of whoever he was in the pod without the protection of
20 CCTV. 11:04

21
22 My biggest regret is the day that I ever let P34
23 walk through the gates of MAH. I feel he is not, nor
24 will he ever be, the same person after what he has
25 endured in MAH. His Daddy and I honestly believed that 11:04
26 he would be going in for a few weeks of assessment but
27 how wrong we were. We feel it is a life that has been
28 lost and we now want to make this up to P34 We
29 hope he can get the best possible life going forward in

1 his new home in the community.

2
3 This has been one of the longest and hardest roads for
4 P34 and my family and I just hope no other
5 vulnerable person suffers similar maltreatment and that 11:05
6 life would be kinder to people with a learning
7 difficulty in the future."

8
9 Then, P34's mother you have got seven exhibits to your
10 statement which I'm not going to read out aloud but the 11:05
11 Panel have all of these. P34's mother having heard me read
12 that part of your evidence, are you happy to adopt your
13 statement as your evidence to the Inquiry.

14 A. Yeah.

15 1 Q. And in your statement, you refer to your daughter, 11:05
16 P34's sister and P34's sister has also made a statement to the
17 Inquiry, and is it right that you have nominated
18 P34's sister to give your family's evidence to the Inquiry
19 about your experience at Muckamore?

20 A. Yes. 11:06

21 2 Q. And there is nothing else that you wish to say to the
22 Panel at this stage then, is that right?

23 A. No.

24 3 Q. Okay.

25 CHAIRPERSON: All right. P34's mother thank you very much, 11:06
26 you are going to be come back a little bit later but I
27 don't think you will be very long until that happens.
28 I just want to thank you for that so far. I know you
29 found it difficult just to be here and to listen to

1 that, and I think we can all understand why.
2 we have been going just longer than hour. would you
3 like a bit of a break, I think, because the next
4 witness is about 20 pages so what we can probably do is
5 if we take the break now and then we can have the next 11:06
6 witness plus the two parts that are under the
7 restriction orders. would that make sense?
8 MS. KILEY: Yes, I think so, thank you, Chair.
9 CHAIRPERSON: So we'll take a 15 minute break now and
10 then we'll start again at about 25 past. Thank you 11:07
11 very much.

12
13 SHORT ADJOURNMENT

14
15 11:07
16
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29

1 THE HEARING THEN RESUMED AS FOLLOWS AFTER THE SHORT
2 ADJOURNMENT

3
4 CHAIRPERSON: Thank you. Welcome, P34's sister thank you
5 very much for coming along to assist the Inquiry and
6 you're about to be sworn.

11:32

7
8 P34'S SISTER, HAVING BEEN SWORN, WAS EXAMINED BY
9 MS. KILEY AS FOLLOWS:

11:32

10
11 4 Q. MS. KILEY: Hi, P34's sister We met earlier this morning
12 and you've now heard your Mum's statement be read
13 aloud, so I won't go over all the procedures again,
14 you've seen how it's done, and I see that you have a
15 copy of your statement in front of you and there is a
16 cipher list there also if you want to refer to it. So
17 if you're ready, what I will do is start reading your
18 statement and then the only difference between what
19 happened this morning with your mum is that after I
20 have finished reading your statement, I do have some
21 questions that I will ask you. Is that okay?

11:32

22 A. Yep.

23 5 Q. And are you what ready for me to start reading? Okay,
24 thank you. So your statement is dated 25th September
25 2023 and you say:

11:32

26
27 "I P34's sister make the following statement for the
28 purpose of the Muckamore Abbey Hospital Inquiry.

1 My connection with MAH is that my brother, P34 was
2 a patient at MAH. The relevant time period that I can
3 speak about is from 2007 to June 2023. I am the older
4 sister of P34 and the daughter of P34's mother and P34's father
5 My mother, P34's mother has also provided a statement to the 11:33
6 Inquiry. I seek to address those issues in which I have
7 had specific dealings.

8
9 To give some context on P34's life prior to MAH, he
10 had mild to moderate learning difficulties, Attention 11:33
11 Deficit Hyperactivity Disorder, and an autism spectrum
12 it disorder. That did not prevent him from being loved
13 by all of us and included in family activities.

14
15 P34 was always overly social and active. I have 11:33
16 many happy memories of when our Daddy took us both to
17 football matches, on mountain walks, to the park and
18 walks around lakes where he went fishing.

19 P34 was more than capable of engaging in such
20 activities and got plenty of enjoyment from them. 11:34

21
22 We have a large extended family and P34 was, and
23 still is, fully part of it. He loved family parties
24 where he spent time with the people who loved and care
25 for him and whom he had fun with and enjoyed singing 11:34
26 songs with. I remember trips to Donegal with the larger
27 family and how much P34 loved to be a part of this.
28 I now feel very sad that P34 is unable to be
29 involved in such family activities and holidays due to

1 his significant deterioration from being
2 institutionalised, secluded and allegedly abused in
3 MAH.
4

5 In January 2020 P34 was moved from the main ward in 11:34
6 Cranfield 1 to the pod in Cranfield 2. My mother has
7 told me that she had been painted a pretty picture of
8 the pod in that it would be a calming area that P34
9 could use to self-regulate. She was also told he would
10 still be able to come and go freely from the main 11:34
11 Cranfield 2 ward. I can state with certainty that it
12 was never proposed to us that P34 would permanently
13 be locked away in the pod with no access to the main
14 ward and secluded from all other patients and staff on
15 the main Cranfield 2 ward. This is what happened until 11:35
16 March 2023.
17

18 The pod was a closed off area at the end of the bedroom
19 corridor in Cranfield 2. It contained three small
20 bedrooms, one named as a bedroom, one renamed as a 11:35
21 living room and one renamed as a dining room. In the
22 living room, there was a small TV, no more than about
23 20 inches, which sat behind a perspex panel. P34
24 is visually impaired, which I believe is a side effect
25 of the medications he has been and remains on, and 11:35
26 therefore, would not have been able to see this TV
27 without difficulty. At one stage there was no sofa,
28 just a sloping chair.
29

1 In the dining room there were no table or chairs to
2 allow P34 to eat. Instead, P34 had to eat his
3 meals in his bedroom at a desk space that was part of
4 the built-in wardrobe. My family had to insist on
5 P34 getting an a sofa and table and chairs. There 11:36
6 were no skirting boards or door frames in certain rooms
7 and the walls" were bare, with no decor whatsoever.
8 The rooms were usually dark as window blinds from not
9 opened by the staff. P34 had a match box sized
10 hole in the window of the locked door to the main ward 11:36
11 to look through.

12
13 Within the pod, there was no access to a garden area or
14 the bath which P34 really enjoyed. I attach
15 photographs of the pod at Exhibit 1. I feel immense 11:36
16 sadness and helplessness when I envisage P34 living
17 in these horrendous conditions.

18
19 My family only became aware of P34's horrendous
20 living conditions in January 2022 when my mother and 11:36
21 father were finally allowed into his living area
22 following relaxation of Covid 19 restrictions. After
23 this visit, I remember the very upsetting call I
24 received from my parents. My parents had both been
25 crying due to becoming aware of the conditions P34 11:37
26 had been living in. From then my family pleaded with
27 MAH senior management to move P34 out of the pod
28 and into the main Cranfield 2 ward until his planned
29 transition to Mallusk occurred. I continually made my

1 views regarding my thoughts on the pod known to senior
2 management, describing it as a prison, seclusion, and
3 not fit for an animal, never mind a human being.
4

5 In or around late summer 2022, we became aware that 11:37
6 there were no CCTV cameras in the pod that P34 was
7 living in, and CCTV may only have been in the corridor
8 area. This was a complete shock to me and my family.
9 We did not believe that there was any area of Muckamore
10 Abbey, except bedrooms and bathrooms where patients 11:37
11 were cared for without CCTV coverage, especially after
12 the alleged abuse within MAH.
13

14 A letter in November 2020 from the MAH service manager
15 at the time, H300, affirmed this belief. The letter 11:37
16 stated how CCTV had been in operation in communal areas
17 from March 2017 and that MAH had hoped to expand the
18 use of the CCTV footage and one reason was to increase
19 the trust and confidence for families. I attach a copy
20 of this letter at Exhibit 2. 11:38
21

22 The lack of CCTV cameras in the pod was raised by my
23 family to senior management during a meeting in
24 September 2022 and followed up in numerous later
25 meetings. The safeguarding team also subsequently 11:38
26 raised the issue of lack of CCTV coverage in the pod
27 following several safeguarding incidents against
28 P34
29

1 I recall a safeguarding incident over Christmas 2022.
2 During a visit to P34 on the 31st December 2022, my
3 mother spotted bruising on P34's lower wrists.
4 They appeared to her to be fading bruises in the shape
5 of thumb marks. When she asked P34 what had
6 happened, he told her the person who did it was H625.
7 When he was asked again the next day, he said the same
8 name. There was no management on the ward on these two
9 days so my mother was unable to report this.

11:38

10
11 We discussed this as family and after failed attempts
12 to contact ward management on 3rd January 2023,
13 I e-mailed H234, Co-Director, raising my concerns and
14 asking her if she would be available to check P34
15 and, in a non-leading way, ask him what happened.
16 I understand that H234 went to see P34 following
17 which she telephoned and e-mailed me to provide an
18 update. She advised that P34 met her and warmly
19 greeted her and he showed his upper body and upper arms
20 upon her request. H234 advised she saw no bruising or
21 fading of bruising and that he had "wee white circles"
22 on his pale skin. I have attached this e-mail chain at
23 Exhibit 3 and confirm H234 also copied in members of
24 staff, H282 and H415.

11:39

11:39

11:39

25
26 Safeguarding staff H240 and H626 came out to my
27 mother's home on the 11th January 2023 to discuss all
28 open and closed safeguarding events relating to
29 P34 We raised this recent incident then. I do

11:40

1 not feel this incident was dealt with well as it was
2 not investigated any further and in my view it should
3 have been.

4
5 During a meeting on the 2nd February 2023 it was 11:40
6 acknowledged by MAH Senior Management that the Belfast
7 Health and Social Trust assurance to ensure CCTV in all
8 areas of MAH where staff delivered patient care was not
9 being met in P34's case. I attach minutes of this
10 multidisciplinary team meeting at Exhibit 4. 11:40

11
12 On the 15th February 2023 during e-mail communications
13 with H626 safeguarding team she informed me that she
14 had been in contact with the Assistant Service Manager,
15 H290, who informed H626 that the CCTV cameras had been 11:40
16 installed and connected but she was awaiting
17 confirmation from estates that they were operational.

18
19 I was informed during a subsequent face to face meeting
20 that the cameras were now in operation. P34 was 11:41
21 living in the pod for over three years without CCTV
22 cameras being in place.

23
24 I always dreaded visiting P34 in the pod. It
25 filled me with great sadness seeing him in this 11:41
26 environment and I felt completely helpless having to
27 walk away and leave him there at the end of each visit.

28
29 Prior to my visits my mother would have had to

1 telephone the ward and let them know we were at the
2 entrance door to the pod which was separate from the
3 main door into Cranfield. The pod entrance was at the
4 side of the building. I remember us having to wait
5 anywhere from 10 to 30 minutes to get into the pod. 11:41
6 I believe this delay was due to attempts to make
7 P34 appear more presentable by changing his clothes
8 or removing incontinence pads. Most of the time when
9 visiting P34 he was poorly dressed, his personal
10 hygiene was obviously not being maintained and he was 11:42
11 usually wearing incontinence pads, which my family
12 would have immediately requested be removed.

13
14 Following my family becoming aware in January 2022 of
15 P34's living conditions in the pod, my mother and I 11:42
16 requested an urgent meeting with the then Ward Manager,
17 H282, Deputy Ward Manager H415 and Service Manager
18 H300. This meeting took place somewhere between the
19 end of January 2022 and the beginning of February 2022
20 and included the Deputy Service Manager, H409. There 11:42
21 were no minutes taken at the meeting. This was the
22 case for all meetings my family had with senior
23 management from January 2022 through to December 2022.
24 I remember members of the senior management team
25 arriving to meetings with post-it notes. I felt the 11:42
26 meetings were very unprofessional and that there were
27 extremely poor follow-through of actions discussed as
28 nothing had been recorded.

1 I initiated e-mails with MAH senior management
2 regarding meetings actions, follow-up and my families
3 concerns. I attach several of these e-mails at exhibit
4 five. These are by no means all of the e-mails that I
5 felt it necessary to send. They are a representative 11:43
6 sample to indicate how often I had to chase up matters
7 with MAH. My family felt like the major concerns we
8 were raising were not being listened to or taken
9 seriously.

10
11 When actions were not being followed through from the 11:43
12 initial meeting that involved the Service Manager,
13 H300, I contacted the then Co-Director for learning
14 disabilities, H627, which led to a formal complaint
15 being recorded. I attach e-mail to H627 dated 1st 11:43
16 March 2022 at Exhibit 6. There were only a few e-mails
17 with H627 before I received an out-of-office e-mail
18 from her and after that I had no more correspondence
19 with her and assumed she had left her post.

20
21 On the 22nd March 2022 I e-mailed the Secretary of the 11:44
22 Co-Director to request a meeting with the Consultant,
23 H530, the Co-Director, who at this time was H233 and
24 the Cranfield 2 Ward Manager. I was offered to have
25 H234 at the meeting who was at this time the MAH 11:44
26 Divisional Nurse which I accepted. I attached a copy
27 of this e-mail at Exhibit 7.

28
29 On 15th July 2022 I e-mailed Dr. Cathy, Chief Executive

1 of The Belfast Trust, to request a meeting with her to
2 allow my family to share our concerns with regards to
3 P34's care in MAH. I detailed that the meetings
4 with MAH Senior Management over the previous six months
5 were unproductive. I attach a copy of this e-mail at 11:44
6 Exhibit 8. Dr. Jack proposed that my family meet with
7 the Interim Director, H522, and that meeting took place
8 on the 16th September 2022 with H234 also present.
9 I have no minutes from the meeting and I have no
10 recollection of any actions coming from this. 11:45

11
12 All subsequent meetings involved H234 as divisional
13 nurse and at some stage she was appointed to the role
14 of MAH Co-Director. I had dealt with four senior
15 managers over the period of nine months. It has been 11:45
16 very unnerving for my family to see that MAH are unable
17 to retain staff at such senior levels.

18
19 At my family's request, minutes have been taken at
20 meetings since December 2022. I wanted to highlight 11:45
21 that I had to follow up on minutes being completed and
22 shared with us. It usually took between six weeks to
23 three months for me to obtain these minutes from MAH.
24 I attach minutes to meetings at Exhibit 9.

25 11:45
26 A Family Liaison Social Worker, FLSW1, has been
27 supporting my family since September 2020. In August
28 2022, when Covid 19 restrictions had been relaxed, we
29 asked FLSW1 to become involved in meetings with MAH

1 senior management.

2
3 FLSW1 has taken immense pressure off my family with her
4 intensive involvement. She is our guardian angel and
5 the most caring, compassionate and trustworthy person 11:46
6 I have come across in the health profession. My family
7 would be lost without the support that FLSW1 has
8 provided and continues to provide.

9
10 FLSW4, Family Liaison Lead Social Worker, has also 11:46
11 supported the family when FLSW1 has been unavailable.

12
13 On the 6th February 2023, my mother and I presented a
14 letter in person to Michelle O'Neill, First Minister
15 Designate of Northern Ireland. This letter highlighted 11:46
16 P34's living conditions in MAH, the impact it was
17 having on him, coupled with the fact he had been
18 recognised as a victim of alleged abuse in MAH and the
19 continued delay in relation to his discharge. The
20 letter requested her support. I attach a copy of this 11:47
21 letter at Exhibit 10.

22
23 I also sent a similar letter by e-mail to Carál Ní
24 Chuilín, Nuala McAllister MLA and John Finucane MP on
25 7th February 2023. These were representatives in my 11:47
26 family's local area.

27
28 Sinn Féin, specifically Gerry Kelly MLA, has been
29 supporting my family since February 2023. I feel his

1 presence at meetings with MAH was key in improving
2 P34's living environment and activity plan. Most
3 importantly, in my view, his attendance was the
4 decisive factor for why P34's transition was
5 prioritised, initiated and followed through. I believe 11:47
6 changes were only made when Gerry became involved and
7 this indicates to me that the Belfast Trust were afraid
8 of potentially receiving more bad media against MAH.
9 I do not think appealing to the politicians should be
10 required to secure proper treatment and resettlement. 11:47
11

12 In the past, there were activities organised for
13 P34 and he had good behavioural support, mainly
14 from H593 who was a behavioural nurse working in
15 Cranfield 1 and PICU. This was a critical element in 11:48
16 P34's improved behaviour. In 2018, when PICU
17 closed and P34 was moved to Cranfield 1, he lost
18 the benefit of H593 skills and level of care. She was
19 moved to work in Cranfield 2.
20

21 Until around mid 2018, just prior to P34's move to
22 Cranfield 1 and having been prescribed Haloperidol
23 P34 was at his best, behaviourally. This was after
24 a considerable amount of attention and work with H593.
25 I have provided two photographs at Exhibit 11 to show a 11:48
26 comparison how P34 appeared during that period in
27 2018 and how he appears now.
28

29 During 2020 when P34 was in the pod and Covid 19

1 restrictions were in force I believe P34 regressed.
2 It should still have been possible to undertake an
3 activities with P34 especially within MAH's social
4 bubble.

5
6 P34 was not provided with any behavioural support
7 and our family only became aware of this in early 2022.
8 It took sustained pressure for over one year to
9 reinstate some form of behavioural activity for
10 P34

11
12 Similarly, it required pressure to secure increased
13 daycare and occupational therapy. Efforts to obtain
14 meaningful physiotherapy and speech and language
15 therapy for P34 was unsuccessful. I cannot
16 understand how it requires such pressure to obtain such
17 basic services for my brother whilst he is in a
18 hospital environment.

19
20 The lack of personal hygiene support that P34 was
21 provided in MAH was shameful. P34's dental record
22 in May 2023 details how he had to have two teeth
23 extracted and had to receive seven new fillings.
24 I remember how past and present, I would have said so
25 staff about supporting P34 in brushing his teeth.
26 However, I felt they always used the excuse that he
27 would not let them do it. P34 would have let my
28 mother clean his teeth but I do believe some staff did
29 not take the time and did not have the patience to do

1 this for P34

2
3 P34 always loved to look and smell clean but his
4 experience in MAH stripped this from him. More times
5 than not, P34 would have been wearing clothes that 11:50
6 were ripped, inside out or too tight due to shrinking
7 from washing at high temperatures and tumble drying.
8 My mother and I regularly bought P34 hundreds of
9 pounds worth of sportswear as we always wanted P34
10 to look well and be comfortable. I would question if 11:50
11 the clothes were being worn by P34 or if some staff
12 were just lifting the first clothes that came to hand
13 which would have been the last set of clothes washed.

14
15 We also purchased bottles of aftershave throughout the 11:50
16 year for P34 but I never smelt any on him and when
17 my family questioned why it was not being used, we were
18 often told it had been misplaced. I would not be
19 surprised if it was taken by staff.

20
21 On numerous occasions, our family noticed that 11:50
22 P34's nails contained faeces. We had to actually
23 ask staff to clean P34's hands. Both P34's
24 fingernails and toenails have been left over grown. My
25 mother started bringing scissors from home into MAH to 11:51
26 cut them.

27
28 P34 has also had issues with his feet, suffering
29 with bunnions, and it was evident that he was

1 uncomfortable with these. This had to be raised by my
2 mother, who had to push and insist on an appointment
3 with the pod terrorist.
4

5 Further, in respect of P34's personal hygiene and 11:51
6 grooming, we requested that P34 was given a facial
7 shave with his electric razor as part of his daily
8 routine. It was evident during visits that there were
9 times when P34 had not been shaved in several days.
10 Similarly, if this was challenged, staff would fob us 11:51
11 off with an excuse such as the charger had been
12 misplaced or lost.
13

14 It became evident to my family during P34's time in
15 the pod that incontinence pads were being used on him. 11:51
16 We raised this as a major concern as P34 was not
17 incontinent prior to being admitted to MAH and we were
18 advised by staff that they were only used at night and
19 on bus journeys. Despite this assurance there have
20 been numerous occasions during visits that P34 was 11:52
21 wearing an incontinence pad. When this has been the
22 case my parents or I would request the pad be removed
23 and we remind staff that P34 is able to use the
24 toilet.
25

26 I believe was down to the laziness of some staff that
27 P34 has ended up in incontinence pads and we, the
28 family, have been lied to. We actually believe MAH had
29 P34 in incontinence pads full time. The issue of

1 incontinence pads is within the handover that was given
2 to Mallusk during resettlement. Mallusk were told by
3 MAH that P34 wears incontinence pads 24/7.

4 It shows how bad the situation is in MAH with regards
5 to maintaining a patient's personal care when The 11:52
6 Deputy Ward Manager at the time, H415, had to put a
7 remainder document in P34's bathroom for his daily
8 personal hygiene to emphasise in relation to his teeth
9 that they must be brushed by nursing staff along, with
10 a tick box personal hygiene checklist. I refer to 11:53
11 copies of each of these documents at Exhibit 12 and
12 Exhibit 13 respectively.

13
14 I feel P34 has been neglected in every aspect of
15 his care in MAH, including his basic personal hygiene. 11:53
16 My family disputed P34's diagnosis of bipolar
17 according to MAH. In our view, the type of behaviour
18 that was being described and labelled at bipolar could
19 equally have resulted in the various medications
20 P34 had been prescribed and in response to the 11:53
21 trauma he suffered. I am gravely concerned that
22 P34 was being overmedicated and I raised issues
23 about the overuse of PRN during MDTMs. I have attached
24 a photo of P34 at Exhibit 14 which shows how he can
25 appear when administered PRN. This is heartbreaking 11:53
26 for me to look at in every aspect.

27
28 He has been left in clothes that have food stains all
29 down them, likely due to him being unable to eat his

1 meals properly due to being highly medicated. His eyes
2 appear dull and sad and his facial expression is blank.
3 This is not our P34

4
5 I asked P34's current consultant, H223, what steps 11:54
6 should be taken before PRN was used. H223 has been the
7 only one with openness and transparency and advised
8 that there were techniques to identify triggers for
9 P34's behaviour and communication steps to
10 deescalate episodes before PRN should be considered. 11:54
11 H223 referred to this as the "calm card". My family
12 were never aware of this approach and I have seen no
13 evidence of MAH attempting the calm card approach with
14 P34

15 11:54
16 In my view, MAH was too quick to resort to medication
17 as a way of managing P34's behaviour rather than
18 try to understand what was producing the behaviour and
19 dealing with that through alternative therapies.

20 11:54
21 The communication between my family and MAH as to
22 exactly what medication P34 was being given and why
23 was never good. However, it was particularly bad from
24 2018 onwards. In a 2018 medication review, it was
25 clear that H50 had started P34 on Haloperidol on 11:55
26 23rd August 2018 as it had been increased to the
27 maximum dosage within three months. These decisions
28 had all been made without my family being notified.
29 I attach a copy of P34's 2018 medication review at

1 Exhibit 15.

2
3 Also on 9th January 2018, H40 prescribed P34
4 Diazepam with Lorazepam as PRN first line. An e-mail
5 from H223 on 19th July 2023 which I have attached at 11:55
6 Exhibit 16 confirms this. P34's behaviour and
7 mental state then deteriorated and he was moved from
8 Cranfield 1 to PICU on 25th January 2018.

9
10 Initially, the dose of diazepam was a low dose but it 11:55
11 was subsequently increased significantly on 26th July
12 2018 and he remained on that for several months despite
13 the fact that it was in his records that he should not
14 be on any benzodiazepines as he is allergic to them.
15 Worst still, the administration of diazepam overlapped 11:56
16 with the administration of Haloperidol on 24th October
17 2018."

18
19 CHAIRPERSON: Sorry, I think until 24th October.

20 MS. KILEY: Oh, thank you, I'll re-read that sentence. 11:56

21
22 "Worse still, the administration of diazepam overlapped
23 with the administration of Haloperidol until 24th
24 October 2018 when the diazepam was stopped.

25 H40 was the doctor who told my mother that P34 was 11:56
26 allergic to benzodiazepines even though he himself had
27 also prescribed them to P34 in later years after
28 telling her this.

29 The names of the prescribing clinicians are included in

1 an e-mail from H223 dated the 11th July 2023. I have
2 attached a copy of this e-mail at Exhibit 17.
3 I only became aware of what medication P34 was
4 being prescribed in August 2022 when our family
5 requested this information from the ward manager at the 11:57
6 time, H415.

7
8 H223 has also sent P34's medication as of the 19th
9 July 2023 to me in an e-mail which I attach at Exhibit
10 18. Based on the official database of medication 11:57
11 information that H223 has supplied in the e-mail
12 P34 is currently on the maximum dose of the
13 following medications: Lurasidone, anti-psychotic;
14 Epilim Chrono, mood stabiliser; Priadel, mood
15 stabiliser; Melatonin, hormone, on higher than 11:57
16 recommended dose.

17
18 He was also previously on the maximum dose of
19 Haloperidol which is an anti-psychotic. This was
20 reduced at my family's request and consultant 11:57
21 agreement.

22
23 P34 is also on procyclidine, an anticholinergenic
24 to counteract the side effects of all the
25 anti-psychotic medications. 11:58
26

27 I believe that it has only been since this year, with
28 the assistance of H223, that there has been any
29 transparency over P34's medication and any

1 willingness to make changes in response to concerns my
2 family have expressed. H223 has also been willing to
3 acknowledge on several occasions that P34 is on a
4 significant amount of medication and he is trying to
5 reduce this to a therapeutic level, but this has only 11:58
6 happened since P34 has started his transition into
7 the community. I believe this has only been possible
8 because H223 feels more able to do this outside of MAH.
9

10 In my view, P34's medication regime in MAH was 11:58
11 chemical abuse and has significantly contributed to his
12 deterioration."
13

14 Then at 58 you say:
15

16 "There were few very caring, compassionate and 11:59
17 supportive staff. I recall H629, an auxiliary nurse
18 who worked the evening shifts, and H593, a behavioural
19 nurse. P34 spoke highly of them and his face would
20 light up when he saw them. He would always have asked 11:59
21 is H629 coming in?
22

23 I remember my mother telephoning me extremely upset
24 after leaving P34 back to MAH after a lovely home
25 visit. My mother informed me that P34 asked Staff 11:59
26 Nurse H459: "Is H629 in" and her response was: "Don't
27 know". P34 then repeated the question and H459's
28 response was, whilst making a gesture of opening her
29 jacket: "She's not in my pocket." My mother was so

1 distressed she said that H495 responded to P34 with
2 a smug grin on her face. She also told me that at this
3 point P34 went pale with extreme anxiety. My
4 mother then asked H459: "Is H629 working tonight?"
5 P34 had his back to H459 as H459 responded with a 12:00
6 wink and nod, indicating H629 was in. In response to
7 this, my mother told me she reassured P34 instantly
8 by saying: "P34 it's okay, your night is made,
9 H629 is in."

10
11 This is just one example I can recollect of how staff
12 can be casually cruel, disrespecting P34 as a human
13 being, teasing him and disregarding his learning
14 disability. This type of attitude and treatment could
15 have a significant negative impact on P34 with 12:00
16 regards to his behaviour. Looking back now I regard
17 this as a form of mental torture towards P34 and if
18 that was how staff thought they could speak and treat
19 patients in front of their relatives, I wondered how
20 they were being spoken to in their absence." 12:01

21
22 Then if you turn to paragraph 65, you say:

23
24 "It has only been over the past year that my family
25 have been made aware of safeguarding issues and the 12:01
26 fact that policies were in place to investigate these.
27 Even so, I believe they are not being followed through
28 in a timely manner and my family have not been provided
29 with regular updates. In my view, a speedy

1 investigation is essential if there are to be effective
2 changes.

3
4 I understand several safeguarding incidents involving
5 P34 that we raised were not investigated by MAH as 12:01
6 safeguarding and, as far as my family are concerned,
7 were not properly explained. An example of this is
8 when we have on several occasions questioned bruising
9 found on P34 and queried as to where and how these
10 bruises had originated. We were told by MAH that 12:01
11 P34 was clumsy and had bumped into a wall or doors
12 and there would have been no further investigation or
13 explanation.

14
15 Another example was when P34 presented with faeces 12:02
16 under his nails. Again this occurred on multiple
17 occasions. When this was raised by family to MAH staff
18 they would become defensive and their attitude would
19 have changed towards us. There was never an
20 investigation into how this was allowed to happen. My 12:02
21 mother raised concerns to MAH staff that this lack of
22 personal hygiene may be a factor as to why there was
23 out breaks of Norovirus on frequent occasions in MAH
24 which P34 was subjected to. I have given an example
25 of a recent safeguarding issue which was highlighted to 12:02
26 me by H626 from the safeguarding team in MAH. A member
27 of the Inreach team from P34's new had reported
28 that two members of the MAH staff pulled the mattress
29 from below P34 whilst he was still in bed. One of

1 the MAH staff said to the Inreach staff: "This is how
2 we do it", which would indicate that this was the
3 normal protocol for certain staff. I understand one
4 member of staff went off on sick when this was raised
5 with them.

12:03

6
7 In relation to P34's difficulty in getting out of
8 bed, this could be caused by several factors such as
9 the high dosage of sedative medications he is on and/or
10 his low mood due to lack of stimulation and the
11 environment he was living in.

12:03

12
13 I should say there were numerous occasions when we saw
14 things in relation to P34 that we considered to be
15 concerning or troubling. We did not always raise these
16 issues because there was a worry about the impact of
17 doing so on P34 whilst he was under their care.
18 P34's resettlement placement was identified with
19 Inspire Mallusk in June 2020. Following significant
20 delays with ongoing staff recruitment and no confirmed
21 date for his resettlement, my family issued judicial
22 review proceedings on behalf of P34 against the
23 Northern Health and Social Care Trust.

12:03

24
25 As a result of the judicial review proceedings
26 P34's resettlement to Mallusk was due to start on
27 31st October 2022 and expected to take six to 12
28 weeks."

12:03

1 And you then, P34's sister at paragraphs 72 to 78, explain
2 a little bit more about the resettlement process and
3 particularly your interactions with the Northern Trust
4 in respect of that. And I am going to pick up the
5 reading there, the Panel has all that, I am not going 12:04
6 to read it all aloud but I'm going to pick up the
7 reading at paragraph 79 where you say:

8
9 "P34 only began his transition in May 2023 and by
10 the 1st of June 2023 he was offered an opportunity to 12:04
11 stay overnight in Mallusk. Since then, P34 has
12 remained at Mallusk and it has been a rollercoaster of
13 a journey for both my family and most importantly
14 P34 I believe his transition has been extremely
15 rushed, in my view due to financial factors and the 12:04
16 fact MAH is now set to close. We were promised that
17 the transition would be at P34's pace which it most
18 certainly has not been. I believe a patient-paced
19 transition is essential for successful placement. We
20 as family cannot see another failed placement for 12:05
21 P34

22
23 MAH have had a big say in P34's routine and passing
24 that information on to Inspire. I do not agree that
25 the routine implemented in MAH was ever in P34's 12:05
26 best interests. I have been told that MAH did not like
27 to do much with P34 in the evening as his bedtime
28 routine started after dinner at about 5.30 p.m..
29 I feel this is ridiculous and deprived P34 of any

1 evening activity or enjoyment. This is something we
2 are insisting is changing in his new home but we are
3 yet to see much change.

4
5 During July 2023, P34 was reduced off Haloperidol 12:05
6 by 0.5 milligrams per week. In the middle of August
7 2023, after about two weeks of being off Haloperidol,
8 P34 was presenting with more challenging behaviours
9 and appeared to be getting more PRN administration.
10 I believe these behaviours may have been influenced by 12:06
11 the sudden departure of a key member of the Inspire
12 team, the activity co-ordinator who worked very well
13 with P34 as he had a great bond her. The
14 behavioural changes may have also been the effects of
15 drug withdrawal. 12:06

16
17 As staff within Inspire are not medically trained, I do
18 not believe they have the expertise to deal with
19 medication withdrawal and additional MAH nursing staff
20 should have been supporting P34 during the 12:06
21 reduction of Haloperidol and the withdrawal side
22 effects he was likely to experience. I do not believe
23 Inspire requested additional staff to support this.

24
25 Following an unsettled week for P34 an emergency 12:06
26 meeting was called on 18th August 2023 by H647 in which
27 the time had to be scheduled around P34's
28 Consultant, H223. Family availability was not
29 considered. The meeting included members of the via

1 settlement team, Inspire Management, both Belfast Trust
2 and Northern Trust behavioural staff, P34's
3 Consultant, our family liaison social worker and my
4 family. During this meeting, the behavioural teams
5 from each the Northern Trust and the Belfast Trust were 12:07
6 in conflict over whose role it was to provide
7 behavioural support for P34 I feel that the
8 actions from this meeting had already been decided and
9 family concerns were not going to be considered. My
10 family raised once again that we felt P34's 12:07
11 resettlement had been rushed and that he was not being
12 provided with the support from MAH that he should be,
13 i.e. behavioural and daycare support was nonexistent.
14 Also, P34 was not being exclusively supported by
15 nursing staff during his medication changes. 12:07

16
17 The actions from the meeting were that MAH were to
18 provide additional supporting staff over the upcoming
19 weekend which they were unsure at that stage they could
20 do and that P34 would commence a new anti-psychotic 12:07
21 Olanzapin at 2.5mg per day. My family felt helpless
22 and that these so-called professionals were not giving
23 P34 a chance to potentially get through this
24 unsettled period. They were wanting him to go on
25 additional medication near enough immediately. 12:08

26
27 Following this meeting, contact was made with our MLA
28 representative, Gerry Kelly, who telephoned H234 and
29 during this conversation she said that the behavioural

1 specialist was on her way to see P34 The
2 behavioural nurse did not turn up so by that stage and
3 to date, there has been no behavioural support input
4 provided to P34 from the Northern Trust or Belfast
5 Trust since he moved to Mallusk.

12:08

6
7 Following this, Olanzapine was increased to 5mg per day
8 as the lower dose was having no improvement effects as
9 reported by Inspire and MAH staff. Since this, P34
10 has had to attend A&E on two occasions; 27th and 29th
11 August 2023 with seizure-like activity. The outcome of
12 his traumatic A&E admissions was that this behaviour
13 was most likely medication-related and that Olanzapine
14 was to be discontinued. I have included the relevant
15 e-mail updates from P34's Consultant, H223 at
16 Exhibit 23.

12:08

12:09

17
18 Although P34 is currently not within the MAH
19 environment, he is very obviously experiencing
20 flashbacks of his alleged abuse in MAH and this is
21 making his behaviour extremely challenging at times.
22 I am unsure whether this has been considered by MAH,
23 the Resettlement Team or Inspire. My family have
24 requested for Psychology input for P34 and to
25 support the staff that work with him to help them
26 understand better what he has been through and how to
27 deal with him when he brings up traumatic memories of
28 the past. We have been informed this will be provided by
29 the Northern Trust when he is discharged from MAH but

12:09

12:09

1 in the meantime we will continue to did if this can be
2 provided by the Belfast Trust.

3
4 P34 has been under the care and treatment of the
5 psychiatric hospital for a period of 16 years and 12:09
6 during that time, he has significantly regressed. By
7 way of example, P34 is now using flash cards for
8 communication whereas previously it would have been
9 possible to explain to him what was going to happen and
10 he would have understood this well. Also, P34 is 12:10
11 now largely double incontinent, his whole presentation
12 is different. P34 is unable to fully communicate
13 the impact on him of his MAH experience. I am
14 concerned that without specialist assistance, no-one
15 will ever know the exact the effects MAH has had on him 12:10
16 or what should be done now to best help him. My family
17 would like P34 to be independently assessed as we
18 have no confidence in the diagnosis and treatment he
19 received in MAH.

20 12:10
21 My family have been left heartbroken because P34
22 was put into MAH with the belief that he would helped,
23 only to find that in fact he has been significantly
24 hurt and damaged by his experience. It is impossible
25 now to give him back the life he would have had if he 12:10
26 was properly looked after."

27
28 P34's sister that ends the substance of your statement.
29 You then go on to give the declaration of truth and

1 list and provide the number of exhibits that you have
2 referred to in the statement. So having heard me read
3 all of that aloud today, are you content that it is
4 accurate, first of all?

5 A. Yes. 12:11

6 6 Q. And do you wish to adopt it as your evidence to the
7 Inquiry?

8 A. Yes.

9 7 Q. Are you comfortable continuing straight to questioning
10 now, you don't need a break? 12:11

11 A. Yep.

12 8 Q. okay. If you do need a break any time you can let the
13 Chair know.

14 A. okay.

15 9 Q. So the first thing I want to ask you about, P34's sister 12:11
16 is the pod, which is the first thing that you dealt
17 with in your statement, and you described how P34
18 was moved from the main ward in Cranfield 1 to the pod
19 which was in Cranfield 2, isn't that right?

20 A. Yep. 12:12

21 10 Q. And that move was in January 2020?

22 A. Yes.

23 11 Q. What were you told at that time as family about why
24 P34 was moved to the pod?

25 A. I think it was actually subsequent to that we were told 12:12
26 that there had been, we have got more details, what
27 there had been safeguarding issues and we were actually
28 given mixed messages. At one point it was safeguarding
29 issues against P34 from other patients and then

1 we've also since heard what it was actually P34
2 there was patient-to-patient safeguarding issues from
3 P34 to other patients. So to be honest, we haven't
4 really got to the root of why he was moved.

5 12 Q. What were you told about what the pod was like at that 12:12
6 time and what facilities it would have for P34

7 A. I don't really think we were actually told much. It
8 would have been my parents that were in a meeting,
9 multidisciplinary meeting, and like I said, they were
10 painting a pretty picture that it was going to be an 12:13
11 area that P34 could move freely to and from and
12 that it was just off the ward, he have access still to
13 the main ward and it would really just be used to allow
14 him to go and calm down and regulate and then he would
15 be able to come back into the main ward again where he 12:13
16 had access to the garden and other staff and other
17 patients, but this wasn't the case.

18 13 Q. How did you know that that wasn't the case?

19 A. We only became aware of that when we got in to see the
20 pod in January 2022. I suppose all over from the Covid 12:13
21 restrictions, we weren't even able to visit him so we
22 were never aware that he wasn't being allowed into the
23 main ward or what it actually looked like.

24 14 Q. So it was January 2022 when your family first saw the
25 pod and you have provided some photographs of the pod, 12:14
26 which I think we can bring up on screen now for IT.
27 These are photos 1 to 6 and, Panel, these photos appear
28 at 24 to 29 of the Exhibits. If we can just bring
29 those photos up and scroll through them, please.

1 So if you look at your screen, P34's sister you will see
2 these first one is a photo of P34 in the pod?

3 A. Yeah.

4 15 Q. When was that taken, roughly even?

5 A. In 2022, this was after.... 12:14

6 16 Q. Okay.

7 A. It would have been probably mid 2022 because we had to
8 fight for him to get a table and chairs.

9 17 Q. Okay. So this is in the table and chairs, you
10 mentioned there were three rooms in the pod. which 12:15
11 room is this in?

12 A. This would have been considered a dining room.

13 18 Q. Okay. And whenever you first saw the pod, was that
14 table and chairs in there then?

15 A. No. 12:15

16 19 Q. So when did it go in, do you know?

17 A. I'm unsure.

18 20 Q. But after January 2022?

19 A. Yes.

20 21 Q. Okay. And go to the next photo then? 12:15

21 CHAIRPERSON: Sorry, what was in the pod before they
22 put that furniture in? What was in that room, can you
23 remember?

24 A. No, I can't remember. At the start of 2022 I was
25 unable to visit, it was only my Mummy and Daddy were 12:15
26 able to visit so I would have to pass that question
27 over to my Mummy, if possible.

28 22 Q. MS. KILEY: Okay. There's another photo coming up, so
29 this is the same room, we can see the table and chair?

1 A. Yeah.

2 23 Q. And a rocking chair then?

3 A. And they had attempted to decorate it by putting that

4 on the wall.

5 24 Q. Yeah. And if we can go to the next photo then please. 12:16

6 These are large files so IT have alerted me to the fact

7 that it can take a little while to move from photo to

8 photo. So what is this a photo of?

9 A. It just shows how grubby it looked.

10 25 Q. What is that on the floor? 12:16

11 A. I think it might have been where there was possibly an

12 old wardrobe or bed that had been taken out for P34

13 to then use that as another room that they considered a

14 dining room.

15 26 Q. So this is the dining room still that we were just 12:16

16 looking at?

17 A. Yes, this is still the dining room. So they never

18 attempted to wipe the floor. It was just grubby,

19 horrible.

20 27 Q. And the next photo, please. So is this now P34's 12:17

21 bedroom?

22 A. No, that's the living room. So they left the -- that

23 would have been what a bedroom looked like, that was

24 one side where they had a small TV, so that would have

25 been a bedroom TV. P34 was never given a big TV 12:17

26 that the other patients would have been able to access,

27 he was just left with what would have been a previous

28 bedroom. That was the size of the TV that he had to

29 view on a daily basis, behind a perspex panel, and

1 there was a window on the other side and if the sun was
2 shining in, there is no way he would have been able to
3 see that TV. And that also would have been the desk
4 space that he would have had to eat his meals on before
5 they got him a table and chairs. 12:18

6 28 Q. Yes. So you described that in your statement, so
7 that's where he would have had his dinner before?

8 A. Only his bedroom, not actually there, but that's the
9 same set-up.

10 29 Q. The same style, okay. And was that TV then changed? 12:18
11 You described your concerns about that.

12 A. It took us literally until -- I think he got a bigger
13 TV put in maybe February/March '23, just before then he
14 got moved into the main ward. But what they were
15 trying to say that they needed to order parts in to put 12:18
16 it behind a perspex screen and in the end they just
17 ended up moving the TV in and just letting it sit on
18 the shelf, and they didn't put it behind a cover.

19 30 Q. CHAIRPERSON: And can I just ask, could P34 change
20 the channel if he wanted to? 12:19

21 A. I don't know.

22 31 Q. CHAIRPERSON: Just looking at that.

23 A. Well, he couldn't have done it touching the TV but I
24 never seen a remote when I was there.

25 CHAIRPERSON: Okay. 12:19

26 32 Q. MS. KILEY: Okay, the next photo then please. What's
27 this we're looking at now?

28 A. This is the sloping chair that he had in that living
29 area before he got a sofa. That would have been all

1 there would have been. And then you can also see marks
2 on the walls. There was no attempt of making the place
3 look presentable before P34 was moved into it.
4 33 Q. So the sofa, is that the brown thing we can see in the
5 corner? 12:20
6 A. Yeah.
7 34 Q. That wasn't always there, is that what you're saying?
8 A. No.
9 35 Q. Before that, there was the sloping chair, just?
10 A. Yes. 12:20
11 36 Q. And was there anything else in that room?
12 A. I can't recollect.
13 37 Q. Okay. And the next photo, which is the last one, what
14 are we looking at in that photo?
15 A. This is the hallway. The door that you can see open is 12:20
16 into the dining room, then there was his bedroom and
17 then where the photo is being taken from would have
18 been a door into the living room, and P34 is
19 looking through into the main ward here. Although that
20 looks like a big window panel he's looking through, 12:21
21 there's like a sticker around it that you can't see
22 there and it's actually only a match-sized box that he
23 is peeping through to look into the main ward.
24 38 Q. On the right-hand side of that photo, we see a closed
25 door there. What's that? 12:21
26 A. Unsure. That was never opened.
27 39 Q. It wasn't something that P34 used?
28 A. No.
29 40 Q. CHAIRPERSON: Sorry to keep interrupting, just so that

1 we understand, his access to seeing what was happening
2 in the outside world, as it were, would be through that
3 little part left open in that window into the ward?

4 A. Yes.

5 41 Q. CHAIRPERSON: And an outside window, was there an 12:21
6 outside window as well?

7 A. On the other side where the photo is being taken from,
8 there was the door into the outside and he couldn't see
9 through it, I think the glass was completely -- it
10 would have been a long panel of glass down it, from 12:22
11 what I can recollect, and it would have been completely
12 covered but some light would have come through it, but
13 not a lot. And that's another thing when you opened
14 that door previously, it was out into the Muckamore
15 grounds, P34 wouldn't have been allowed out there 12:22
16 and we had to fight for him to get -- it was like a
17 grass area and we had asked for a fence to be put round
18 it so he could access his own garden because they
19 weren't letting him into the main ward to access that
20 garden. And it took -- we had asked for that I think 12:22
21 in May '22 and it took them until about
22 October/November '22 to fence it off because they
23 didn't just fence it off, they then decided to pave it,
24 they ripped up all the grass and paved it and it just
25 literally looked like a prison courtyard, it was 12:22
26 horrendous. So that would have been what P34 would
27 have then got out in, but by that stage it was the
28 winter.

29 42 Q. CHAIRPERSON: And he was in this pod, did you say, for

1 three years?

2 A. Yeah, over three years.

3 43 Q. MS. KILEY: During that three year period, P34's sister
4 did P34 get any therapies whenever he was in the
5 pod? 12:23

6 A. Again, over Covid we were told due to Covid
7 restrictions, there was very little they could do with
8 him but, really, Muckamore were in their own private
9 bubble, there should have been still daycare support
10 which he wasn't getting and we had to fight for that 12:23
11 once we became aware of what he had been living in and
12 that he wasn't getting access to the main ward and when
13 we asked, you know, can he get daycare, can he get out
14 and about, we had to fight for it and then it was only
15 about March 23, again I feel it was from when we had 12:23
16 MLA involvement, that they started putting all this
17 effort into P34 but by that stage, he was then
18 going through the resettlement process so I feel they
19 were just doing it to keep us happy until he got out
20 the door. 12:24

21 44 Q. You mentioned there daycare. So are you saying that
22 whenever he moved to the pod, he wasn't leaving the pod
23 to access daycare?

24 A. No, there was days he was just locked in there all
25 day/every day and weekends as well. We found even when 12:24
26 there was daycare when we had fought to get it in place
27 again, daycare very rarely happened over the weekend so
28 P34 could have been in there from a Friday until a
29 Monday and it was only my Mummy and Daddy or me going

1 up at the weekends would have broken up his weekend.

2 45 Q. Were staff constantly with him in the pod?

3 A. There was always one staff member but again, you know

4 with the safeguarding issues that we have had to deal

5 with, with him being there, I just had no trust in any 12:25

6 staff, well very little staff, and the fact he had only

7 had the CCTV recording in that hallway area, we just

8 didn't know what was going on in the other rooms.

9 46 Q. And you said in your statement that you continually

10 raised your concerns about the pod once your family 12:25

11 found out what it was like, and that you pleaded for

12 P34 to be moved out of the pod?

13 A. Yep.

14 47 Q. Did you have a named person at Muckamore who you could

15 bring your concerns like that to? 12:25

16 A. No. The first port of call usually would have been the

17 Ward Manager but like I said, they were chopping and

18 changing all the time and it was so hard to keep up

19 with who was actually in charge, and then I would have

20 went as high as the Co-Director and then when that 12:26

21 failed I went even higher.

22 48 Q. And you have provided the Inquiry with some of your

23 e-mails or examples of the contact that you made in

24 your exhibits, I am not going to take you through all

25 of them, but one of the things that you say in your 12:26

26 statement is that you were asking for P34 to be

27 moving from the pod from February 2022 when you found

28 out that that's where he was and that's what it was

29 like but he wasn't moved out of the pod then until May

1 '23, is that right?

2 A. March '23.

3 49 Q. March '23. So were you given an explanation as to why
4 it took so long to move him out?

5 A. During the meetings we would have had, they would have 12:26
6 said; 'Oh, we could attempt, you know, we don't think
7 it's a good idea to move him completely because he has
8 been so used to being in the pod, we'll do it
9 gradually, we will slowly break him in, we'll take him
10 down for maybe the morning where it's a bit quieter, 12:27
11 and then he can go from there to daycare.' This is
12 when daycare was up and running again. But they put
13 these plans in place and never followed through, and we
14 were going from one meeting to the next, and I was
15 asking for updates on how it was progressing and they 12:27
16 would have used the excuse that they were understaffed
17 or the ward was unsettled or P34 was unsettled, and
18 we just never seen any progress. And then all of a
19 sudden March '23, they just moved him straight in,
20 there was no transition. So to me, they were just 12:27
21 trying to put it off for as long as possible because
22 they thought he was out of sight/out of mind in the
23 pod.

24 50 Q. When you say there was no transition, was there a
25 re-introduction process before he went in? 12:28

26 A. No.

27 51 Q. Okay.

28 A. This is what they had tried to say they would do but
29 they never did. And then, when we had the meeting in

1 March '23 with our MLA present it was on a Friday,
2 I think, and by that Monday P34 was just moved into
3 the main ward and he was put on -- so he went from
4 being on a one-to-one staffing to I think a two-to-one
5 when he moved into the ward until he resettled back in. 12:28

6 52 Q. How did he manage moving back into the main ward?

7 A. We were told that there was incidents and that that's
8 why they increased staffing numbers on him, but that
9 was to be expected. He had been locked away for three
10 years, had very little contact to the outside world 12:28
11 because of Covid and then he didn't have the support
12 that he should have been getting through daycare and
13 other supports that the hospital should have been
14 providing, so obviously he was going to go in and be a
15 bit elevated when he seen other people and patients and 12:29
16 staff, he was always just so used to being with one
17 staff member. You know, some of the staff would have
18 been really caring with him but others, they wouldn't
19 have had much communication with him and based on what
20 we witnessed, they didn't give him the care and support 12:29
21 that he needed in terms of his physical support.

22 53 Q. You refer to engaging with a number of people at
23 Muckamore about your concerns about the pod, you've set
24 all that out in your statement, and one of the things
25 that you say is that you did eventually make a formal 12:29
26 complaint to the Belfast Trust about P34's living
27 conditions and you provided that complaint letter that
28 you submitted in your exhibits. For the Panel's
29 reference, it is at page 52, I don't think we need to

1 turn it up, but what you have provided is your letter
2 to the Trust making the complaint and I wanted to check
3 with you have you received a formal written response
4 from the Trust to that complaint letter?

5 A. To be honest, I can't recollect if I did or not because 12:30
6 there was much going on trying to actually fight to get
7 him out of the pod and then we were also trying to get
8 his re settlement process initiated to get him out of
9 Muckamore completely. So I can't remember whether I
10 got an e-mail follow-up from it or a letter, I honestly 12:30
11 don't know.

12 54 Q. Okay. The next topic that I want to ask you about is
13 P34's medication. And one of the things that you
14 pick up in your statement is that P34 has an
15 allergic to benzodiazepines? 12:30

16 A. Yep.

17 55 Q. You describe that in detail. When was that allergy
18 discovered?

19 A. It was -- my Mummy would have been told.

20 56 Q. Was it when he was in Muckamore? 12:31

21 A. Yes.

22 57 Q. It was when he was in Muckamore?

23 A. Yeah.

24 58 Q. And what type of reaction would he typically have?

25 A. I think he was restless, he just couldn't -- his 12:31
26 behaviour wasn't good when he was on it so the doctor
27 then said he was allergic with it, he would have
28 completely went off as they considered baseline so it
29 wasn't having any beneficial effect on him and that was

1 any of the benzodiazapine drugs that he would have went
2 on had that effect on him so that's why -- I'm just
3 looking at which doctor. H40 had told my Mummy that he
4 was allergic to benzodiazepines but then he
5 subsequently put him back on to diazepam in 2018 and 12:32
6 that is when his behaviour then went off again and he
7 was then just put on other medications because they
8 were putting it down to P34's behaviour but,
9 really, it was his reaction to a drug that he shouldn't
10 have been on again. 12:32

11 59 Q. When did you ...(interjection)
12 DR. MAXWELL: Can I clarify, did the doctor say an
13 allergy or reaction? Because they are two different
14 concepts.

15 A. I can't answer that. 12:33

16 60 Q. DR. MAXWELL: You didn't get anything in writing? You
17 haven't seen anything?

18 A. No, there's nothing in writing, but I think it is in
19 his written medical notes.

20 61 Q. DR. MAXWELL: You have seen it in his medical notes? 12:33

21 A. I haven't seen it in his medical notes but I'm almost
22 sure his current consultant has told us that it's in
23 the medical notes that he is allergic to.

24 DR. MAXWELL: Thank you.

25 MS. KILEY: There are some care plans not exhibited to 12:33
26 this witness's statement but exhibit to P34's mother's
27 statement and they are the last exhibit to her
28 statement and there is a note there about, I think it
29 says allergy, I'll check the language, but there is a

1 reference there. Just one of the things that you refer
2 to in your statement, we are talking about this issue,
3 is a medicine review that happened and if we could
4 bring that up please, page 87 of the exhibits.

12:33

5
6 So we can see there is a two-page document, the first
7 page is on your screen there and you see that the first
8 sentence refers to a review at end of 2017 and 2018 to
9 see if any factors, particularly in relation to his
10 medical, that contributed to a more positive clinical
11 presentation can be identified. Do you know what
12 brought about that review why it took place at that
13 time?

12:34

14 A. So we, as a family, had asked the doctor to look back
15 to that time period. His current Consultant, H223, we
16 had asked him could he review that period and tell us
17 what medications he was on. So that's why.

12:34

18 62 Q. So when did he conduct the review?

19 A. That was July '23.

20 63 Q. Okay, so the review was conducted in July '23 but it
21 was a look-back at this time?

12:34

22 A. Yes.

23 64 Q. And that was by a different doctor, isn't that right?

24 A. The review?

25 65 Q. Yes.

12:35

26 A. Yes, the review is by his current consultant so he was
27 looking back at his medical notes.

28 66 Q. Okay. And we can see there, if you scroll down to the
29 date, the 25th of January '18, if you just keep

1 scrolling down and pause there, you can see there under
2 the 25th January '18, there is reference to diazepam,
3 2mgs, and then if you keep scrolling down, we can see
4 the 26th of July 2018, there is another reference
5 "diazepam increased" and if we scroll to the next page 12:35
6 please, and pause there, on 24th October 2018 there is
7 a reference to diazepam being stopped. So at that
8 time, so in and around the 2018 period, was your family
9 aware that P34 had been prescribed diazepam?

10 A. No, we were unaware of any of these medication changes. 12:36

11 67 Q. Since now becoming aware of it, did you receive an
12 explanation of why that occurred?

13 A. No, his current consultant can't, I suppose, give
14 reason for why another consultant has put P34 on
15 this. 12:36

16 68 Q. Okay. In your statement, whenever you're discussing
17 the medication, you say that in your view, P34's
18 medication regime was chemical abuse and I just wanted
19 to ask you what you mean by that phrase?

20 A. The amount of medication he has been on over the years 12:36
21 is just ridiculous. His current consultant has said to
22 us on multiple occasions that P34 is on a lot of
23 medication and that he wants to try and get him off as
24 much as he possibly can, and when I just look at that
25 review over a period of a year and see the medications 12:36
26 he has been put on and taken off and I just find, put
27 him on one and they have him straight up to the maximum
28 dose within a short period of time, and they have never
29 given him a chance to adjust to maybe a lower more

1 therapeutic dose to see how he would perform on that,
2 they just put him up to the top dose, have him on that
3 and then counteract the side effects of that with
4 another drug, and that's what I mean by chemical abuse,
5 because they are just putting one medication into
6 counteract another side-effect and he is on the top
7 dose of everything.

12:37

8 69 Q. And during P34's time period in Muckamore, did your
9 family have regular contact with the prescribing
10 clinicians about what medication P34 was on?

12:37

11 A. My parents would have attended MDT meetings I think
12 every six to eight weeks. I wouldn't have attended
13 them with them in the earlier days and from what I am
14 aware, I think some consultants were better than others
15 at making them aware of what medication P34 was on,
16 but I don't think they knew to the extent of what he
17 was on. It might have been, like, the one main drug
18 that he would have been on and not all the others that
19 would have been given to him to counteract the side
20 effects.

12:38

21 70 Q. Okay. One of the other things you talk about in your
22 statement is what you describe as the overuse of PRN.
23 why do you feel that it was overused in P34's case?

24 A. When he was in the pod, he very rarely got PRN because
25 he was with one member of staff and like I said, we had
26 fought for him to get out to be moved back into the
27 main ward and I feel when he was moved into the main
28 ward, the use of PRN was being given basically every
29 day and I felt that they were trying to make a point

12:38

1 that; 'we told you P34 couldn't cope in this
2 environment, he's too elevated, we need to be giving
3 him this medication every day to calm him down', and
4 really it was just sedating him and turning him into --
5 they were just trying to sedate him and have him sit in 12:39
6 the corner doing nothing and they didn't need to do
7 that in the pod because he was in such a small area and
8 when we would have asked, you know, what was done
9 before you gave him PRN, because we were told by his
10 Consultant that it should be a last resort, they never 12:39
11 had, they could never support that they had tried other
12 strategies before giving it to him.

13 71 Q. In terms of putting a time period then on that concern,
14 you're referring to the time period when P34 moved
15 out of the pod and back into the general ward. So is 12:40
16 that the only time you had a concern about PRN?

17 A. No, it would have been previously as well. There was
18 times in the pod that he was being given PRN as well
19 and we questioned that, and again they couldn't give us
20 good reasoning for why he was given it, they might have 12:40
21 just said; 'Oh, he was off baseline', but there was
22 never; 'we tried X, Y and Z before we gave it to him.'
23 It is only his recent, his current Consultant had made
24 us aware that other strategies should be used, this
25 calm card he referred to it as, and we had never heard 12:40
26 any of those approaches being used before PRN was
27 given.

28 72 Q. Did your family ever get an opportunity to share with
29 staff at Muckamore the type of strategies that might

1 help P34

2 A. We would have raised in meetings how we felt P34

3 should have been approached and, you know, if staff are

4 nice to P34 and staff speak to P34 in a

5 respectful manner, P34 would appreciate that and he 12:41

6 responds better to that. Communication is so key with

7 him and it just felt we were talking to the wall you

8 know. You know, it never felt -- like I said, they

9 never made notes at meetings, there was actions

10 discussed and then nothing ever came of it. I always 12:41

11 felt I had to come out of meetings and send a follow-up

12 e-mail to, you know, basically have something in

13 writing that what we had discussed in the meeting,

14 because I knew I was never going to get it from them.

15 I can't really remember where I was going with that. 12:41

16 73 Q. That's okay. I know you have a photo that you want the

17 Panel to see of how P34 presented whenever he was

18 on PRN, so this is at page 86 of the exhibits. I think

19 ITU, you have it as 101?

20 CHAIRPERSON: I think it's 84? 12:42

21 MS. KILEY: 86 in your exhibits but IT are working

22 with slightly different numbering because of the size

23 of the files.

24 CHAIRPERSON: okay.

25 74 Q. MS. KILEY: Is this the photograph that you wanted the 12:42

26 Panel to see?

27 A. Yes.

28 75 Q. What do you want them to understand about this

29 photograph?

1 A. This is not P34 this is just horrendous. My mummy
2 had taken this photo and she sent it to me when she got
3 back, she was extremely upset.

4 76 Q. When was it taken, P34's sister

5 A. I would say sometime in 2023, I can't recollect when, 12:43
6 but this is not just a one-off, this is just not a one
7 off, we would have seen him like this when he was on
8 PRN and even when he wasn't on medication, this is the
9 type of way he would have been presented in terms of
10 his clothing, his hair, just looked untidy, not clean. 12:43
11 But his face there, you can just see how sad he looks
12 and looking at that, I just feel numb, it just isn't my
13 brother.

14 77 Q. I know you also have photographs that you want to
15 compare that with, so now might be a good time to bring 12:44
16 those up. These are at pages 82 and 83 of the
17 exhibits, 9 and 11 for IT.

18 A. Yeah.

19 78 Q. When was this one taken, P34's sister

20 A. This, I think, was maybe like Spring '18 and that's 12:44
21 whenever we seen -- he was doing really well, this was
22 before he was started on Haloperidol and you can see
23 that's the build P34 is before he gets medication,
24 he was always a slim build fella, always liked to look
25 clean and tidy and smell nice and he's happy there. 12:45

26 79 Q. Was that taken at home, that photo?

27 A. Yeah, that's actually in my house, yeah.

28 80 Q. Okay. And the next photo then please?

29 A. So he would have been able to come home and visit at

1 that stage, my Mummy and Daddy would have called in
2 with him there at my house, there would have been no
3 staff or anything with him, but now that just wouldn't
4 be possible.

5 81 Q. Okay. You can see...(interjection) 12:45

6 A. This is more recent. I think this has been taken from
7 he's moved out of Muckamore. He looks happy there but
8 you can see the amount of weight he has on him because
9 of the medication he's on.

10 82 Q. CHAIRPERSON: That's at Hazelbank, isn't it? 12:46

11 A. Yeah.

12 83 Q. MS. KILEY: And those are the pictures that show the
13 comparison of P34 in different times.

14 A. Yep.

15 84 Q. You've explained a little bit in your statement about 12:46
16 how the things that P34 used to be able to do that
17 he can't do. Can you say anything more to the Panel
18 about how P34 changed since being in Muckamore and
19 the type of things that he used to be able to do that
20 he now can't do? 12:46

21 A. Basically everything, you know, something as simple as
22 just sitting down with his family and eating his
23 dinner, now, like, we feel like when P34 gets food
24 put in front of him, he, like, rushes to eat it and
25 looking back now, is it because it was ripped away from 12:46
26 him, you know, when he was -- and he feels now he has
27 to eat it as quickly as possible before it's taken from
28 him. P34 could have sat with us as family and he
29 would have come even in his early days in Muckamore and

1 had dinner with us every Sunday and we would have sat
2 as a family and ate together, being able to go out
3 walks together, like, again in the earlier days my
4 mummy would have went up to visit, and I would then
5 have picked her up after work and we could have walked 12:47
6 P34 around the grounds of Muckamore with no issues
7 whatsoever. Like, looking to now in the later years
8 what he has turned into, you know, two staff had to
9 come out with us because they were afraid of him
10 running away or running towards people and it's just 12:47
11 not him.

12 85 Q. Is that still the case now if you go out with P34
13 two staff need to go with him?

14 A. Even from when he's been resettled, he hasn't had a
15 home visit yet, he hasn't been taken out. His 12:48
16 behaviour is just a bit too unpredictable at the minute
17 still and that could be, I suppose, to do with a
18 complete change of environment, his medication being
19 changed, a multitude of reasons, different staff, but
20 he is just too unpredictable to be able to do that. He 12:48
21 was never that nature, didn't have that unpredictable
22 nature. You could always predict him and, like, talk
23 to him to calm him down and I just feel like that's
24 been stripped from him, it was just; 'Throw medication
25 into him and that will calm him down', and I feel like 12:48
26 that's just destroyed him and we want him to be reduced
27 off as much as possible now because in the long-term,
28 ,what effect is that going to have on his physical
29 health, not just his mental health in terms of his

1 liver and kidneys. I don't want to be sitting in years
2 to come with him having issues there. Yes, simple
3 things even his own personal hygiene, you know, he
4 could have went into the toilet and used the toilet
5 himself and washed his hands and whatever. Like I 12:49
6 said, they just pumped incontinence pads on him and
7 left him to it.

8 86 Q. Okay. P34's sister those are all the questions that I
9 have for you about this part of the evidence. The
10 Panel may have some? 12:49

11 CHAIRPERSON: I think Dr. Maxwell has some.
12

13 P34'S SISTER WAS THEN QUESTIONED BY THE PANEL AS
14 FOLLOWS:
15

16 87 Q. DR. MAXWELL: Yes, I just want to go back to the PRN.
17 In Exhibit 9, which is on 173 to 175, which is an MDT
18 meeting on 27th April this year, there is a discussion
19 that you had raised some concerns about whether there
20 was a pattern about certain staff giving more PRN? 12:49

21 A. Yes.

22 88 Q. DR. MAXWELL: And although they said this wasn't
23 apparent, they did actually say towards the end of the
24 paragraph headed: "Use of PRN medication and calm
25 card: 12:50

26
27 "The Use of PRN medication per patient is tracked each
28 week."
29

1 Did you ever get to see the document? Do you know what
2 they were tracking?

3 A. No. I had asked this on a few occasions, I had said,
4 do you know, we feel that depending on what staff are
5 working with P34 what management are in charge of, 12:50
6 you know, giving out the PRN was depending had on how
7 much he had got and would it be possible for them to
8 track it? And I said: "I don't want to know names,
9 even if you can just code them, and just see if you are
10 seeing a pattern". And they didn't really agree to 12:50
11 this and then all of a sudden at one of these meetings
12 they said; 'Oh, we do do that and we track it but we
13 don't see any trend', but they were never willing to
14 share any of that information.

15 89 Q. DR. MAXWELL: They didn't tell you exactly what they 12:51
16 were tracking?

17 A. No.

18 DR. MAXWELL: Okay, thank you.

19 CHAIRPERSON: I have asked my questions as we've gone
20 along and Professor Murphy has no questions. But we do 12:51
21 now need to move into restricted session. I am aware
22 that witness has been going for quite a while. What I
23 am tempted to do is take quite a short lunch and then
24 reconvene with the witness afterwards. Is that going
25 to cause problems for the next witness though? 12:51

26 INQUIRY SECRETARY: I'll just check.

27 CHAIRPERSON: Yes, if the witnesses would rather carry
28 on, then we can carry on.

29 MS. KILEY: Chair, while the secretary is doing that,

1 I will just update in response to Dr. Maxwell's earlier
2 question about whether the benzodiazepines were noted
3 as an allergy or a reaction, I referred you to the care
4 plans and the page number is 63 in respect of P34's mother's
5 exhibits. So that's where you find it. It states -- 12:52
6 this is a Northern Trust care plan. It says "allergic
7 to" and benzodiazepines are listed.

8 DR. MAXWELL: I think they wouldn't have had that first
9 hand. Whether we had any evidence of it from the
10 medical records from the Belfast Care Trust and maybe 12:52
11 that's something we will pursue separately.

12 CHAIRPERSON: Tell me where we are with timing?

13 MS. KILEY: I am being told, Chair, both witnesses
14 would rather continue, if that's suitable to the Chair
15 and to the Panel. 12:52

16 CHAIRPERSON: Okay, no, of course, we can keep going as
17 long as you want to. Does that work for you?

18 A. Yes, I just kind of want to get it done.

19 CHAIRPERSON: I understand, all right, as long as you
20 can still concentrate and give us your best, all right. 12:52

21 A. Yes.

22 90 Q. MS. KILEY: Perhaps the thing do then is to start with
23 you, P34's sister since you remain in the Chair, so if you
24 give me a moment, we will just turn up the relevant
25 paragraphs. 12:53

26 CHAIRPERSON: 57, I think.

27
28 THE HEARING THEN WENT INTO CLOSED SESSION
29

1 THE HEARING THEN WENT INTO OPEN SESSION

2
3 CHAIRPERSON: Now we're quite tight on timing today, two
4 witnesses, three witnesses actually this afternoon.

5 MS. KILEY: Three this afternoon, one of which is just 13:07
6 to be read. So P118's mother's statement is to be read
7 and P118's sister will give live evidence and then P8's
8 mother is schedule for 3:30.

9 CHAIRPERSON: Okay. well, it might be a slightly
10 later end, I suspect, than that. I do think everybody 13:08
11 needs 45 minutes, though, at least. Can I ask, please,
12 that we start promptly at five to two.

13 MS. KILEY: And I should flag up that there may be an
14 application for a Restriction Order in respect of
15 P118's mother. I will liaise with PSNI about that and 13:08
16 provide clarification about that at the outset.

17 CHAIRPERSON: Okay. Five to two. Thank you very much.

18 LUNCH ADJOURNMENT.

1 THE HEARING RESUMED AS FOLLOWS AFTER THE LUNCHEON
2 ADJOURNMENT:

3
4 CHAIRPERSON: Are we using first names or.

5 MS. BRIGGS: We are using ciphers, Chair. 14:12

6 CHAIRPERSON: Ciphers OR first names?

7 MS. BRIGGS: Just ciphers.

8 CHAIRPERSON: Okay. Right, good afternoon. Oddly, I am
9 going to have to call you "P118's mother" and you'll
10 just have to get used to that, I am afraid. You 14:13
11 understand the reasons for that?

12 A. Yes, I do indeed.

13 CHAIRPERSON: You are now going to be sworn in.

14
15 P118'S MOTHER HAVING BEEN SWORN WAS EXAMINED BY MS. 14:13
16 BRIGGS AS FOLLOWS:

17
18 91 Q. MS. BRIGGS: Okay, P118's mother, you can hear me okay?

19 A. Yes.

20 92 Q. You can hear me okay? 14:13

21 A. Yes. Thank you.

22 93 Q. All right. I have explained to you what I am going to
23 be doing this afternoon, which is reading the statement
24 that you have provided to the Inquiry out loud for
25 everyone to hear, okay. I have explained to you that 14:14
26 there may have been an application for a part of the
27 evidence to be restricted, okay?

28 A. Yes.

29 94 Q. That has been granted okay, so there are two paragraphs

1 you'll notice, that I won't read at this stage okay.
2 Those will be read at a later session later on this
3 afternoon, okay, when I'm done reading the rest of the
4 statement. Are you content that I start to read then
5 at this stage?

14:14

6 95 Q. CHAIRPERSON: You have got the statement in front of
7 you, if you want to follow it.

8 A. Yeah.

9 MS. BRIGGS: Okay. So picking up at paragraph 1.

10
11 "My connection with MAH is that my son, P118, was a
12 patient in MAH. I attached a photograph of my son at
13 Exhibit 1. The relevant time period that I can speak
14 about is four separate periods between approximately
15 1983 to 2017.

14:14

16
17 My son, P118, was born in 1973. P118 is aged 49 years
18 old. Prior to P118 being admitted to MAH, he lived at
19 home in the community with our family, including his
20 sister and brother. P118 was fit and healthy and
21 enjoyed cycling and could cycle eight to 10 miles in a
22 day.

14:15

23
24 P118 was born with severe learning difficulties
25 accompanied with autistic symptoms. P118 did not
26 receive a formal diagnosis that I'm aware of. It may
27 have been during P118's third admission that he was
28 formally diagnosed or labelled. P118 has required
29 constant care and attention from birth. P118 also

14:15

1 suffers with high levels of anxiety and stress. P118
2 is verbal and has good communication skills and can
3 understand right from wrong. P118 can identify if he
4 is being mistreated.

14:15

6 P118's first admission to MAH was in or around 1983 or
7 1984. He was admitted to Ward M7, an admissions ward,
8 for around three to four months for assessment. P118
9 had been disruptive at school, home and at his activity
10 club. The aim was to lower P118's anxiety, which has
11 worsened since leaving MAH. At the time of P118's
12 first admission to MAH, I think that his consultant was
13 Dr. H268, Consultant Psychiatrist. This admission was
14 organised by an approved social worker from the South
15 Eastern Trust.

14:16

14:16

17 I would have visited P118 for two hours every day when
18 he was admitted to M7. P118 cried every day. The ward
19 was like a prison. It was very dark, there were bars
20 on the window and the staff wore uniforms that
21 resembled prison officers. It was not a nice place.
22 Visits became an absolute dread. P118 and I were both
23 anxious.

14:16

25 P118 was admitted again in or around the late 1990s or
26 early 2000s when he was around 25 years old and was
27 admitted for approximately 12 months in Ward M7. The
28 purpose of the admission was to reassess P118's
29 medication as his behaviour had deteriorated.

14:16

1 Dr. H268 lived quite close to our family home. For
2 some reason P118 had gone around to his home on a
3 bicycle, knocked down on his bin and shouted at the
4 house while still on the road. I believe his
5 readmission all stemmed from that. During his 14:17
6 admission his Consultant was Dr. H268 and his social
7 worker from the South Eastern Trust was SW17.

8
9 P118 was discharged after about twelve months to live
10 at home with me and my partner. I sent a letter to 14:17
11 P118's Consultant requesting his discharge, which was
12 granted. I wanted to see if we could get P118 more
13 settled, which did not happen.

14
15 P118 was living alone in the family home for around 10 14:17
16 months until he was re-admitted to MAH in July 2009
17 with support from myself, his sister and her partner.
18 I would have visited him in the morning, during the day
19 and then last thing at night. I organised his personal
20 care, his food, his clothes and his medications. At 14:18
21 the weekend, his sister and her partner stayed with him
22 for the whole weekend. This arrangement had the
23 support of P118's Psychiatrist Dr. H49, Consultant
24 Community Psychiatrist, who wanted to see if P118 could
25 manage living by himself in a supported living 14:18
26 environment. It worked well when our family were
27 present but it was difficult to leave P118 alone. The
28 arrangement of just our family providing support could
29 not be sustained. P118's mental health deteriorated

1 even with all the help and support and the decision was
2 made for him to return to MAH.

3
4 P118 was admitted on the 10th July 2009 to Cranfield 1
5 ward for less than 24 hours. P118 called himself an 14:19
6 ambulance asking for help and was taken to Lagan Valley
7 Accident & Emergency unit. P118 and I were told that
8 Lagan Valley Hospital could not admit him to their
9 psychiatric wards and that he would have to be
10 transferred to MAH. An out-of-hours approved social 14:19
11 worker came to Lagan Valley Hospital to assist with the
12 admission to MAH. I drove P118 to MAH accompanied by
13 the approved social worker who travelled in a second
14 car. The admission took place at about 3:00 a.m. and
15 P118 was discharged the next day by Dr. H601. 14:19

16
17 P118 was further readmitted to MAH as a detained
18 patient on 13th July 2009. The purpose of P118's
19 admission was again for assessment of his mental health
20 and a review of his medication. P118 was admitted to 14:19
21 the Cranfield 1 Men's Unit. The decision to admit P118
22 was taken by his GP..."

23
24 And you name who that is.

25 14:20
26 "...who I understand retired on 31st march 2023. P118
27 called an ambulance asking for help and his GP then
28 arrived. The GP could not get a social worker and
29 asked me to sign for a detention. It was very

1 difficult. P118 was 35 years old and a big man and he
2 had started to hallucinate. I remember one day
3 Dr. H268 had said to me that some day it would get too
4 much for me and I would have to ask for help.

14:20

6 When P118 was admitted in July 2009 it was hoped that
7 with treatment, he would be able to return to live in
8 the community. The family house was available for him.
9 We hoped that he would be able to live there with the
10 support of care staff. However, P118 remained detained 14:20
11 in MAH for nearly eight years. At the time of P118's
12 first and second admissions to MAH, the wards were old
13 and Victorian. The wards were very small with windows
14 that had bars across them on the outside to prevent
15 opening. M7, the Admission Ward, had small barred 14:21
16 windows that prevented light and ventilation which made
17 the ward dark and uninviting. The ward felt more like
18 a prison with patients sharing dormitory-style bedrooms
19 which were usually noisy which, all-in-all, gave no
20 relief to any of the patients with mental ill-health in 14:21
21 receiving the peace and quietness they required in
22 making a recovery.

24 The staff presented more like prison wardens instead of
25 hospital staff who should have been showing empathy and 14:21
26 compassion to their patients, especially to someone as
27 young as P118, who was on his first admission.
28 Instead, they looked tough and unwelcoming with their
29 very short hair, white shirts, dark trousers and boots.

1
2 We were pleasantly surprised when P118 was readmitted
3 in 2009 to see that some of the old Victorian wards had
4 been replaced with new spacious wards with larger
5 windows to give plenty of light to improve the 14:21
6 well-being of the patients and staff working in them.
7 The windows did not have bars on them, opening out a
8 short distance only to give good ventilation, a
9 welcomed all round change for the good and welfare of
10 the patients. 14:22

11
12 Staff were wearing recognised uniforms. The reception
13 area was also large and well lit, having a very
14 pleasant receptionist who appeared to know the names of
15 all patients and staff. This made it very welcoming 14:22
16 indeed on entering the building. I was hopeful that
17 P118's admission to the ward would be different this
18 time.

19
20 If a patient objected to the staff's very strict 14:22
21 routines they were frog-marched in an unkindly manner
22 and pushed into the seclusion room and left there
23 unattended until the staff decided to let the patient
24 out again. P118 was able to tell me in great detail
25 how patients were put into seclusion. It happened 14:22
26 quite frequently.

27
28 There was a lot of shouting and other verbal abuse from
29 staff towards patient all of which instilled fear in

1 the patients. I felt that P118 became so fearful of
2 staff members that he would not ask or even explain how
3 he was feeling to staff because he was afraid of being
4 told off or laughed at, which was often used as
5 psychological abuse with patients.

14:23

6
7 As P118 has autism, he is unable to understand or read
8 facial expressions. This meant that he had become
9 confused, frightened and terrorised when someone was
10 being abusive or unsympathetic towards him. He was not
11 used to that treatment at home.

14:23

12
13 After each admission to MAH, P118 found hospital wards
14 very frightening and stressful. He spent a lot of time
15 crying both in the wards and at visiting time, wanting
16 to go home because he was afraid of both staff and
17 patients.

14:23

18
19 Although the surroundings had changed when P118 was
20 admitted for the fourth time, the staff's attitude and
21 behaviour towards the patients had not changed. The
22 staff carried their old habits from the old to the new
23 environment. Staff continued to use punishment as a
24 tool towards their own gains and advantages. Kindness,
25 empathy and compassion was in short supply for many
26 patients. I wish to clarify that not all the staff
27 working in MAH fell into the category of being loud and
28 abusive to their patients.

14:24

1 There appeared to be a greater number of staff working
2 within the new wards with a good mixture of both gender
3 and age. I felt that incidents were not being reported
4 by staff. One of the reasons why I suspected that
5 incidents were not being reported, particularly by 14:24
6 junior staff, was that there were many staff members
7 from the same family. I suspect that if two staff who
8 were working together and were related, incidents of
9 abuse were not being reported. I was also aware that
10 there was a great sense of fear not only displayed by 14:24
11 the patients but also the junior staff members. One
12 junior staff member came close to talking about what
13 was happening but appeared to stop from giving out the
14 information. I think it was because she was afraid.
15 There was a palpable sense of fear and secrecy in 14:24
16 around the wards.

17
18 P118 was in Cranfield 1 and Killead Wards. He was also
19 admitted to PICU on multiple occasions. We were told
20 that he was being admitted to PICU as his behaviour was 14:25
21 aggressive and very disruptive. We were not informed
22 properly about what had triggered to P118's behaviour
23 which led to the perceived need to place him in PICU.

24
25 Throughout P118's stay at MAH he remained a detained 14:25
26 patient. We were told he was being detained for his
27 own well-being and safety. We were told that because
28 he was able-bodied and he could have walked out, they
29 could not stop him without being a detained patient and

1 this would have created a risk to P118.

2
3 We did attend Mental Health Review Tribunals, maybe one
4 or two of these during his third admission. This was
5 in or around 2002. The hospital provided a solicitor 14:25
6 who represented P118. It was my understanding that the
7 purpose of the Review Tribunal was to see if P118's
8 mental health had improved but it had not. If
9 anything, it had gotten worse.

10
11 I am a retired nurse. I worked as a nurse for 36 years
12 in Musgrave Park Hospital and Lagan Valley Hospital.
13 I question the training levels and nursing care ability
14 of the staff at MAH. They seem unable to properly
15 recognise when a patient may be ill and require medical 14:26
16 attention.

17
18 Many of the patients engaged in swallowing
19 inappropriate and often dangerous objects. This is
20 something that P118 had not done before his admission 14:26
21 to MAH. In or around 2010 when P118 was based in
22 Cranfield 1, he swallowed two batteries, one of which
23 he discharged but the other lodged itself in the bowel.
24 Staff were not checking for the second battery to be
25 passed. As a result, it remained in his bowel where it 14:26
26 leaked and caused a large inflammatory abrasion with an
27 accompanying abscess in his bowel. P118 became very
28 unwell but the staff were very reluctant to have him
29 seen by a doctor.

1
2 I recall having to beg a night nurse to get P118 seen
3 by a doctor or taken to Antrim Area Hospital. The
4 nurse initially refused and told me that a doctor would
5 be on shift later. I later learned that there was no 14:27
6 doctor in MAH during night shifts at that time. The
7 night nurse telephoned me in the morning to say that
8 P118 was very unwell and he was on his way to the
9 hospital. An x-ray taken in Antrim Area Hospital
10 showed that P118 required surgery immediately. The 14:27
11 surgeon telephoned me to inform me that he was going to
12 have to remove part of P118's bowel but he hoped he
13 would not have to do a colostomy that would leave him
14 with a colostomy bag for the rest of his life.

15 14:27
16 The consultant telephoned me after he got out of
17 theatre to inform me that the surgery had been
18 successful, that he removed part of P118's bowel but he
19 had not had to carry out a colostomy.

20 14:27
21 Since P118's discharge to a resettlement place..."
22
23 which you have named there.

24
25 "...his then psychologist, H602 in the South Eastern 14:27
26 Health and Social Care Trust informed me that P118,
27 like other patients who swallow batteries, did it
28 because they wanted to get out of the situation whereby
29 someone was hurting them. I was told that it was

1 regular occurrence at MAH and that P118 also broke CDs
2 or DVDs and tried to swallow them to try and kill
3 himself. I was shocked that P118 had resorted to
4 anything so desperate. This was all behaviour learned
5 in MAH.

14:28

6
7 It was not until P118's fourth admission to MAH that
8 anyone thought to a range of P118's brain to try and
9 identify the source of his behaviour and assist with
10 directing his treatment. Instead, the form of
11 treatment P118 received whilst in Muckamore was
12 predominantly administration of medication.

14:28

13 In or around 2011, P118 was referred to the Royal
14 Victoria Hospital for a brain scan. The scan showed
15 that P118 had developed before birth an arteriovenous
16 malformation in the front lobe of his brain which was
17 inoperable. I was told that this malformation impacts
18 on communication and behaviour skills. I had been told
19 that there is a 1% increase in risk each year of a
20 brain haemorrhage.

14:28

14:29

21
22 This is the only official diagnosis that I have ever
23 received about P118's brain function and conditions.
24 When P118 was assessed at The Royal, the Consultant
25 Neurologist could not understand why P118 was
26 prescribed so much medication and in particular such a
27 high level of Epilim. The consultant apologised to
28 P118 and promised him that they would oversee that the
29 number of drugs prescribed would be reduced. He said

14:29

1 they would request the withdrawal of Epilim as P118 did
2 not require it.

3
4 The drug was not withdrawn but only greatly reduced.
5 P118 continues to be administered a large amount of
6 medication and I am concerned about their effect on
7 him, especially after being informed that at least one
8 of them could be removed altogether.

14:29

9
10 I felt that after the brain scan and the diagnosis that
11 the care plan at Muckamore did not change. The staff
12 at Muckamore never told me that they received a letter
13 from the Consultant about the reduction of P118's
14 medication. Staff did not seem accepting of it or it's
15 implications for his care. I believe that the risk of
16 rupture should have been considered, explained to staff
17 and factored in to P118's care as I know of someone who
18 had an intravenous malformation in the front lobe of
19 their brain who suffered two brain haemorrhages.

14:30

14:30

20
21 In or around 2014 or 2015, I discovered that P118
22 appeared to be suffering from a chesty cold.

23 I requested P118 be assessed by a doctor. I was
24 promised that P118 would be seen the following morning.
25 From my own nursing background, I recognised that P118
26 was becoming very ill. Despite assurances from staff
27 when I returned the next evening, P118 still had not
28 been visited by a doctor. I was again promised that he
29 would be seen in the morning.

14:30

14:30

1
2 The following evening, I found P118 extremely unwell
3 and he still had not been seen by a doctor.
4 I requested he be seen immediately and stated that I
5 would not leave until this happened. The Staff Nurse 14:31
6 was very hesitant in getting a doctor even though she
7 was aware that P118 was very congested. I recall her
8 saying to me that P118 only needed a drink of water and
9 went and got a glass of water. I told the nurse that I
10 would not be leaving P118 until he was assessed by a 14:31
11 doctor. The nurse pulled a face and eventually went to
12 get a doctor for P118. The doctor then requested
13 P118's observations to be taken and within minutes of
14 her checking his observations, a doctor crashed through
15 the door and came to P118's aid. It was like something 14:31
16 you would see on television. The doctor diagnosed P118
17 with double pneumonia and proceeded to inform me that
18 he was having him transferred to Antrim Hospital for
19 admission and treatment as soon as possible.

20 14:32
21 P118 was extremely ill for the next two weeks and had
22 to be nursed for four days in the ICU unit in the hope
23 of saving his life. Thankfully he recovered. An MAH
24 staff member who had sat with P118 in Antrim Hospital
25 told me that another patient, who was admitted a short 14:32
26 time after P118, and while P118 was still an in-patient
27 in Antrim Hospital, had also been diagnosed with
28 pneumonia and sadly died. If I had not insisted that I
29 wanted P118 to be seen by a doctor before I left on the

1 third day, P118 would not be here with us today.

2
3 When P118 returned to Muckamore after his discharge
4 from Antrim Hospital, I requested an interview with
5 Dr. H40, the Consultant. I attended a meeting with 14:32
6 him, together with my daughter. H12, the ward manager
7 from Cranfield Mens Ward accompanied Dr. H40. I told
8 Dr. H40 and the ward manager that this was the second
9 time that P118 had come very close to death owing to
10 neglect of care at the hospital. I asked what he was 14:33
11 going to do about it as our family were concerned
12 regarding P118. He said that the Ward Manager had come
13 up with the idea of getting P118 extra help. That
14 meant that one member of staff, usually a junior staff
15 member, would always accompany him during the day and 14:33
16 night. He said that this would mean that if P118 was
17 having a problem of any kind he would this staff member
18 who would sort the problems out as they ensued.
19 Funding was requested and agreed with P118 being
20 granted a one-to-one staff member with him for the 14:33
21 remainder of his stay in the hospital.

22
23 P118 developed Type 2 diabetes in or around 2015.
24 Since P118's admission to Muckamore in 2009, P118's
25 diet and whole way of life was largely under the 14:33
26 control of Muckamore. I became concerned about P118's
27 lack of exercise. I believe it was a contributor to
28 the development of his diabetes which I regarded as
29 avoidable. I requested many times for exercise to be

1 incorporated into his routine but nothing was really
2 done to avoid or manage his diabetes through diet and
3 exercise.

4
5 I requested an interview with ward management after I 14:34
6 saw a junior member of staff, whose name I cannot
7 recall, was shouting abusively towards P118. A few
8 weeks after this incident, security cameras were
9 installed in the communal day and dining areas. I was
10 interviewed by the Assistant Ward Manager, H79, who was 14:34
11 accompanied by her senior Staff Nurse, H459. P118 had
12 told me that H79 and H459 were abusive towards him and
13 other patients as they both regularly shouted at them.
14 P118 explained to me this was very frightening for him
15 and the other patients. Shouting at patients was a 14:34
16 regular abuse by some staff to patients.
17 During the interview they listened to my complaint
18 regarding the behaviour of the junior staff member.
19 I was asked for the name of the junior staff member but
20 nothing else was said by either Nurse H459 or H79. 14:35
21 H79 was the Assistant Manager and let Muckamore in 2016
22 or 2017 to nurse in England.

23
24 P118 later informed me that I had wasted my time as the
25 two staff mentioned continued to shout and be abusive 14:35
26 towards their patients. Other patients' family members
27 expressed to me their concerns of abuse that was going
28 on in the wards. Staff seemed to take absolute delight
29 in triggering and annoying patients.

1
2 On one occasion P118 was forced to the floor and then
3 dragged by staff members along the corridor from his
4 bedroom to the day space. This was apparently prompted
5 by him sitting quietly in his bedroom listening to his 14:35
6 radio when they wanted him to come up to the day space
7 which was noisy and unsettling. They ended up
8 disallowing him his radio and taking it from him.
9 P118 has a routine of music programs that he loves to
10 listen to every day. Due to his autism, routine is 14:36
11 extremely important to him. I felt that this was not
12 considered but that the staff routine took preference.
13 This type of change to P118's routine often triggered
14 him and then was called bad behaviour. When we would
15 have been informed that P118 had a bad behaviour we 14:36
16 would have asked who was on duty and it was always the
17 same staff; H79 and H459.

18
19 P118 was forced into a seclusion room by staff members
20 for bad behaviour. This occurred on numerous 14:36
21 occasions. I was shocked to listen to a director in
22 Muckamore speak on television, BBC News, that the
23 seclusion room was only used on rare occasions as this
24 was not my experience.

25 14:36
26 One evening, P118 was forcefully pushed into the
27 seclusion room because he asked for a chocolate biscuit
28 with his tea. He was shouted at and made to feel awful
29 in front of all of the other patients who were all

1 allowed a biscuit. He was forced into the seclusion
2 room at 7 p.m.. He was not allowed out either by the
3 day staff or the night staff until 12.30 a.m. the
4 following morning. He was kept in the seclusion room
5 with its padded walls and floor with only one chair to 14:37
6 sit on in the room without a cup of tea or drink of
7 water. He did not receive any supper or the facility
8 of a nearby toilet. P118 also missed his favourite
9 radio show which airs at seven to 10 p.m. which would
10 have greatly increased his anxiety and distress. 14:37
11 When one of the PICU staff, H603, came to the door of
12 the seclusion room, she laughed and jeered at P118
13 through the window. P118 said he asked to use the
14 toilet. However, H603 just walked away saying: "We
15 have got you now." P118 was so afraid of staff 14:37
16 shouting at him if he wet his clothes, he told me he
17 made the decision that he would urinate on the floor
18 instead. It was only when P118 was exhausted, calling
19 and crying for staff to come and let him out to go to
20 bed that they finally let him go to bed at 12.30 a.m.. 14:38

21
22 P118 was often put into the seclusion room whilst he
23 was in PICU. This caused him further physical and
24 mental distress as the room itself was not therapeutic
25 and the staff did not look after him when he was placed 14:38
26 there.

27
28 P118 also dreaded the medicine rounds when Staff Nurse
29 H459 was the one administering the tablets. P118 told

1 me that she always hurt his mouth by forcing a medicine
2 glass between his lips and forcing him to swallow
3 multiple tablets all at ones. I had been informed by
4 the speech and language therapist that P118 had a poor
5 swallow and required to have his medications
6 administered one by one on a spoon at each medicine
7 round."

14:38

8
9 Skipping then to paragraph 50 at the bottom of that
10 page.

14:38

11
12 "One of the medications prescribed when P118 was home
13 had been greatly increased in terms of its dosage on
14 his admission to Muckamore. I felt P118 was very
15 sedated with the amount of medication that he had been
16 prescribed. I felt that this was a means of managing
17 him rather than treating him. This greatly annoys me
18 because very often the staff do things to trigger
19 P118's behaviour in the first place and then say that
20 medication or seclusion are necessary to control
21 behaviours which staff themselves have caused.

14:39

14:39

22
23 As well as mental abuse, P118 endured physical abuse
24 from various staff members while in his bedroom and
25 shower room. P118 informed me that on one occasion,
26 two care workers, H604 and H605 were supposed to be
27 supporting him to shower, dress and go to the toilet.
28 P118 had requested help with toileting from H604 and
29 H605 but they refused to help him. As P118 did not

14:39

1 want to be left unclean he again requested help. He
2 was told by one of the staff members to do it himself.
3 This refusal created a trigger which resulted in P118
4 shouting at the staff to come and help him. At this
5 point H604 caught P118 around the neck forcing him
6 against the wall. P118 was then forced to the floor
7 where the other staff member, H605, kicked P118 with
8 his booted foot in his buttock area. P118 was in the
9 Killead ward when this incident occurred.

14:40

10
11 I reported the incident to the senior Staff Nurse
12 called H606. He promised to investigate the incident
13 and speak with the staff. I was not informed any
14 investigation ever occurred. In any event, the two
15 staff members involved remained working at the
16 hospital. H606 was moved to another ward soon
17 afterwards. P118 was afraid to report the incident as
18 he thought the two staff members would come back and
19 attack him again.

14:40

20
21 I felt that staff were not properly trained in
22 restraining techniques. After being restrained, P118
23 would complain for days of either knee pain or painful
24 fingers or neck pain. I also felt that mishandling of
25 patients could be avoided if staff were prevented from
26 creating triggers for patients by their own poor
27 behaviour.

14:40

28 On another occasion P118 told me that a male care
29 worker whose name I cannot recall was working with him

14:41

1 one morning while showering and toileting and had
2 caught him in the genital area and put him to the
3 floor. P118 was unable to tell me what else happened.
4 He just said the care worker told him that if he
5 reported the incident what he would give him more. 14:41
6 This threat led him not reporting the incident until he
7 saw the man while shopping with staff in Antrim. P118
8 said the man was smirking at him and he made the
9 decision to report the incident as he had not seen him
10 working around the hospital. I told P118 that I would 14:41
11 report the incident. I was contacted by a hospital
12 safeguarding nurse called H607.

13
14 I told the safeguarding nurse what P118 had told me
15 about the incident. I asked if this male member of 14:42
16 staff was still a member of staff at Muckamore. H607
17 said she did not know but advised that she would find
18 out. H607 later advised me that this individual was no
19 longer working at Muckamore. I also asked if she knew
20 if this man was now working with vulnerable adults or 14:42
21 children. H607 said she was unaware if he was employed
22 and promised to find out. She telephoned later to
23 inform me that the man was not working with vulnerable
24 adults or children. She did state that she was
25 reporting the incident to police. P118 was interviewed 14:42
26 sometime later by a police constable with a social
27 worker named SW18 who is currently P118's care manager
28 within the community. SW18 remained in that post until
29 the beginning of 2022.

1
2 P118 told me about the incident after he had been
3 resettled out of Muckamore to a resettlement place
4 which is run by the Priory Group where he currently
5 lives. He told me that a male staff member whose name 14:43
6 I cannot recall was supervising him overnight in his
7 bedroom. Whilst he was asleep during the night, the
8 staff member awoke him as he got into P118's bed. He
9 then proceeded to put his hand on P118's genital area.
10 P118 was crying as he was afraid in the darkened room 14:43
11 with the door closed. He said the man stayed for quite
12 a while in his bed. I asked if he had reported the
13 incident to the staff either day or night. P118 said
14 he did not as he felt they would not believe him as the
15 man came across as a nice man. This staff member has 14:43
16 been sacked from Muckamore because of an incident with
17 another patient. P118 told me that this staff member
18 used to escort him to meet me in the visiting room.

19
20 P118 also told a resettlement place staff member about 14:43
21 this incident. This information was provided to the
22 supervisors at the resettlement place who told P118's
23 Care Manager, SW18. The incident was reported to the
24 Belfast Trust's Adult Safeguarding Team. H254
25 contacted my daughter in September 2020 to inform me 14:44
26 about the next steps in relation to investigation and
27 procedure.

28 Due to Covid 19 restrictions, an ABE interview with
29 P118 only took place on 4th April 2022. Our family

1 have not been told about the outcome of the interview.

2
3 The shortage of staff was a regular problem at
4 Muckamore. One staff member confided in me what they
5 could be asked after working all night on duty to go 14:44
6 home and have a few hours sleep and come back after
7 lunch for duties until 8 p.m. that evening at the
8 hospital. I did not think this was a safe practise for
9 either patients or staff.

10 14:44
11 My family and I believe that P118 was held in Muckamore
12 for too long. We feel what he could have been
13 resettled much earlier with an appropriate community
14 support package, particularly as the family home was
15 available for him. 14:45

16
17 I discussed with now retired social worker SW17 of the
18 South Eastern Trust with regards to P118 returning on
19 discharge from Muckamore to his own home..."

20 14:45
21 And you say where that is.

22
23 "...along with one or two other adults, all of which
24 would have a package of care to support. SW17 felt
25 that it was not a consideration as it had been P118's 14:45
26 home and he may not want to share it with others.
27 I felt that SW17 dismissed P118's return to that place
28 much too lightly.

1 I later became aware that plans were ongoing with
2 regards to the planning and building of two apartments
3 as sheltered accommodation, premises known as..."

4
5 And you name those, and I will be referring to them, as 14:45
6 I already have, as the resettlement location.

7
8 "The resettlement location was at this time
9 accommodating six other residents. The care provider
10 was called Priory Group. There was a temporary care 14:45
11 manager called...."

12
13 And they are named.

14
15 "The temporary care manager was more interested in 14:46
16 meeting the needs of management in Muckamore in
17 supporting getting as many patients as possible out of
18 Muckamore as the media had been highlighting the number
19 of patients in Muckamore for many years without a
20 discharge procedure in place. It was the temporary 14:46
21 care manager who liaised with Dr. H40 regarding the
22 planning and overseeing of the two apartments.

23
24 P118 was never asked if he would be happy living at the
25 resettlement location. I was invited to visit the new 14:46
26 apartments. On arrival, I was shocked as it looked
27 like a prison cell. It looked dark and claustrophobic
28 with no view at all. It was not suitable for someone
29 with mental and physical health problems. I feel that

1 it has contributed to the deterioration of P118's
2 overall health in the last six years. We were not
3 consulted in the planning process and we were told that
4 is where he was going and there was no alternative.

14:46

5
6 With the knowledge I now have of the neglect and abuse
7 that P118 suffered, I believe that much of his
8 challenging behaviour was a response to that and the
9 staff misread or misinterpreted his behaviour. Had he
10 been treated properly or had there been any attempt to
11 understand what might be triggering his outbursts,
12 I believe he could have been discharged back to his own
13 home with a support package.

14:47

14
15 In 2017, P118 was discharged to the resettlement
16 location. I believe P118's discharge should have
17 involved a proper explanation of P118's diagnosis of
18 brain arteriovenous malformation and its implications
19 for his care. This was not done, and our family has
20 had to verbally remind everyone supporting P118 of this
21 diagnosis.

14:47

14:47

22
23 On the 20th June 2020, the Priory Group gave P118 his
24 28 day notice to leave their care. Our family were
25 unaware that P118 was apparently under some sort of six
26 month review period between the Priory Group and the
27 South Eastern Trust. Co-incidentally, I had real
28 reason in reporting the uncleanliness of P118's
29 apartment as well as his poor diet on many occasions to

14:47

1 his Care Manager SW18. Even though I had expressed my
2 concerns for P118 already to all levels of staff at the
3 resettlement location, our family appealed the Priory
4 Group's decision as they were requiring P118 to leave
5 in the middle of a pandemic and without any discharge 14:48
6 plan. The Priory Group rejected the appeal.

7 Several Best Interest Meetings were held between
8 family, Prior Group and South Eastern Trust during
9 which our family made it clear that P118 would not be
10 leaving the care of the Priory Group until a discharge 14:48
11 plan was created, naming his next appropriate
12 accommodation and providing appropriate care support.
13 The Priory Group continued to put pressure on our
14 family verbally and via telephone calls to remove 118
15 from their care. 14:48

16
17 P118 is now seeking his secondary settlement back to
18 his home area..."

19
20 And that place is named. 14:48

21
22 "...with a support package. There was little or no
23 formal written correspondence received by our family
24 regarding any of P118's admission. Communications
25 about admissions consisted of either face-to-face 14:49
26 meetings or telephone calls with Muckamore staff and/or
27 South Eastern Trust social workers.

28 In my view, given the importance and significance of an
29 admission to a psychiatric hospital, the family should

1 be provided with paperwork setting out the date of
2 admission, reason for it, the likely duration, what is
3 likely to happen, the ward, and the consultant
4 psychiatrist responsible for their care. In due course
5 I believe that paperwork should be provided setting out 14:49
6 any diagnosis and the care plan. Important procedures
7 such as those relating to restraint and seclusion
8 should also be explained and any guidance about them
9 provided, as should the complaints process. None of
10 this happened through all P118's four admissions and 14:49
11 discharges.

12
13 During P118's time in Muckamore he had several personal
14 items stolen such as his CDs and his DVDs. No
15 explanation was ever provided nor were the items ever 14:50
16 recovered.

17
18 P118 had his own bank account and he managed this with
19 my help. Generally there were no problems with
20 misappropriation of money but I helped P118 with his 14:50
21 bank account and sometimes requested receipts from
22 Muckamore for anything they bought with him.

23
24 P118 did not have an advocate in MAH. After discharge
25 we learned that he could have been provided one through 14:50
26 the Belfast Trust but we were not informed about these
27 services at the time. At the last meeting before
28 discharge from Muckamore, I was approached by a male
29 advocate employed by Bryson Care who handed me a

1 service card if P118 required assistance on discharge.
2 Our family did in fact require these services and they
3 continue to provide services and support in which we
4 are very grateful for. P118 is most of all grateful.
5 We were not told at any admission stage that we could
6 have had the support of an advocate.

14:51

7
8 P118 was admitted to Muckamore to improve his mental
9 health. However, his mental health deteriorated during
10 his fourth admission and the eight years he spent
11 there. I believe this was due to the lack of care and
12 abuse he suffered there."

14:51

13
14 I am going to skip the next paragraph and then after
15 that, P118's Mum, you gave a declaration of truth where
16 you confirm the contents are true and correct, or true
17 to the best of your knowledge and belief, and you sign
18 and date the statement.

14:51

19
20 Okay, so I am going to ask you two very straightforward
21 questions, hopefully, okay. Are you content that what
22 I have read out there is accurate?

14:51

23 A. Yes.

24 96 Q. And are you content to adopt that as evidence to the
25 Inquiry?

14:51

26 A. I am.

27 MS. BRIGGS: Chair, Panel, that concludes the open
28 session of this part of this witness's statement.

29 CHAIRPERSON: Yes, certainly. We have got a nice

1 photograph, I think, at page 21 but we have looked at
2 that. So there's a photograph.

3 A. Yes.

4 CHAIRPERSON: And we have had a look at. So shall we
5 go into restricted session which I think we can do very 14:52
6 quickly?
7 If we cut the feed to Room B please.

8

9 THE HEARING WENT INTO A RESTRICTED SESSION

10 14:52

11

12 THE HEARING WENT INTO OPEN SESSION

13

14 P118'S SISTER HAVING BEEN SWORN WAS EXAMINED BY
15 MS. KILEY AS FOLLOWS 14:55

16

17 97 Q. CHAIRPERSON: I am going to refer to you as P118's
18 sister.

19 A. Yes, that's right.

20 CHAIRPERSON: All right. So welcome to the inquiry and 14:55
21 I will hand you over to Ms. Kiley who I know you have
22 met.

23 98 Q. MS. KILEY: Good after, P118's sister. We met briefly
24 earlier this afternoon and I explained the procedure
25 for giving evidence. I am referring to you, as you 14:55
26 have heard, as P118's sister, and we have discussed the
27 reasons for that. You, I know, are going to try to
28 refer to your brother as P118. That can be difficult
29 and if you want to refer to him just as "my brother"

1 then that's absolutely fine too. So as you know, the
2 first thing that I have do is read out your statement.
3 You should have a copy of your statement in front of
4 you there and then just above that, you will see the
5 cipher list as well. As you know, I am not going to be 14:56
6 saying some of the staff names so if you want to follow
7 along, you will see the ciphers there. So are you
8 ready for me to commence reading now and then I'll ask
9 a few questions?

10 A. Yes, okay. 14:56

11 99 Q. Thank you. So you made your statement, it's dated 24th
12 August 2023, and you say:

13
14 "I, P118's sister, make the following statement for the
15 purpose of the Muckamore Abbey Inquiry. 14:56

16
17 My connection with MAH is that my brother was a patient
18 in MAH. The relevant time period that I can speak
19 about is four separate periods between approximately
20 1983 to 2017. I am the sister of P118 who is currently 14:56
21 aged 49 years old. My mother, P118's mother, has also
22 provided a statement to the inquiry.

23
24 P118 was born with severe learning difficulties,
25 accompanied with autistic symptoms. P118 has good 14:57
26 communication skills. He understands right from wrong
27 and knows if he is being mistreated. P118 is verbal.
28 Before P118 was admitted to MAH, he lived at home in
29 the community. He is about 5'9 inches in height. He

1 was fit and healthy. He enjoyed cycling and could have
2 cycled 30 miles in a day.

3
4 I wish to address those issues with which I have had
5 specific dealings. P118 is now seeking resettlement 14:57
6 back to his home area with a support package and I have
7 been assisting with this. This would be P118's second
8 resettlement from leaving MAH since 2017.

9
10 I think that leadership was an issue in MAH. The 14:57
11 leadership was not there to ensure staff were able to
12 deal properly with P118. Whilst P118 was in MAH
13 between July 2009 and May 2017 I visited him twice a
14 week. This was to give P118 emotional support and
15 interact in positive activities to assist with his 14:58
16 mental health recovery. We did trips to the cinema,
17 picnics, car drives, walks with my dogs and went out
18 for dinner. We also enjoyed Christmas stay-overs.
19 I provided P118 with these activities as I believed he
20 required private family time together and respite from 14:58
21 the ward environments he was being exposed to and
22 treated in, within MAH. These activities also provided
23 P118 with relaxing sensory needs for a healthy
24 well-being and mindset. Our family currently carry out
25 the same activities today. These activities with 14:58
26 family gave P118 hope and something to look forward to
27 during his very long treatment in MAH.

28
29 Whilst P118 was in MAH, I observed P118 demonstrating

1 signs of being heavily medicated. For example, his
2 eyes rolling in his head, slurred speech, falling
3 asleep quickly and tripping over his own feet when
4 trying to walk. I asked ward staff on numerous
5 occasions why P118 was displaying these signs. I was 14:59
6 always advised that P118's behaviour that day required
7 further medication which I now know is called PRN
8 treatment to manage the situation.

9
10 When I enquired what P118 had done to require further 14:59
11 administration of medication, the staff response was
12 always negative towards P118's behaviour and
13 presentation. For example, it was P118's own fault
14 that he needed further medication because he was
15 shouting or kicking out at staff. I never heard 14:59
16 hospital staff being accountable for any of their own
17 actions during any of these incidents. I would refer
18 to this treatment type as chemical control and a highly
19 inappropriate response to manage an unsettled moment in
20 P118's life, bearing in mind the situation may have 15:00
21 been triggered by a member of staff.

22
23 P118 would have regularly disclosed to me what staff
24 would upset him daily. P118 felt frightened. He said
25 staff would laugh at him, shout at him, they swore at 15:00
26 him and had punched him. P118 had explained to me that
27 he had told staff that he was not a punching bag and to
28 stop it. He told me that staff just laughed and walked
29 away.

1
2 If I questioned nursing staff, it was always dismissed
3 with the explanation that incidents started with P118
4 and his presentation on that day. I was also advised
5 that P118 fabricated stories to get staff into trouble. 15:00
6 I know P118 and I know this to be untrue. P118 had
7 also explained to me that staff would have taken his
8 treasured radio away from him while sitting relaxing
9 and listening to a favourite radio show. P118 uses a
10 radio for sensory needs. He finds the radio a 15:01
11 comforter and the music is a soother. P118 continues
12 to enjoy this activity today. The staff at MAH would
13 not have taken this on board. They would have taken
14 P118 away from his radio to engage in some other
15 activity, for example, saying that he had to watch TV. 15:01
16 This would trigger P118 and they would then describe
17 P118 as being aggressive.

18
19 P118 also would have told me that the staff would have
20 put his earphones on him while listening to the radio. 15:01
21 He told me that they would turn the volume loud so that
22 he could not hear what they were saying. They would
23 tell him not to listen to them. I believe this could
24 have contributed towards hearing problems that P118 has
25 developed. 15:01

26
27 P118 is very aware when an individual is being
28 overpowering by their own physical and mental attitude.
29 I believe that these behaviours from professional MAH

1 staff had an enormous detrimental effect on P118's
2 mental health, bearing in mind this environment was
3 meant to be professional safe space for treatment and
4 recovery.

5
6 I observed P118 being stripped of any form of
7 confidence he ever had by exposing him to unkind
8 environmental hazards, the product and service created
9 from the lack of leadership and knowledge from all
10 management levels within MAH. I strongly believe
11 P118's treatment could have been shortened if he had
12 received a better planned relaxing sensory environment
13 filled with nursing empathy to support his care needs.
14

15 Instead, I observed P118 receive his treatment in a
16 noisy, harsh, unsympathetic and chemically controlled
17 environment. I believe that this also put P118 at
18 further risk from abusive behaviours created by staff
19 within the site. This era of P118's life was
20 harrowing.

21
22 During P118's treatment in MAH he never told me about
23 any sexual abuse he was enduring. I believe P118 was
24 too troubled to make me aware of such incidents.
25 However, in the summer of 2020 he did disclose to me an
26 incident about a past event that occurred whilst he was
27 in MAH between 2009 and 2017. At this time, I did not
28 know about the incident P118 was referring to as P118
29 had reported it to support staff member in the

1 residential facility where he currently resides. The
2 staff member, named H890, had reported this information
3 to the management where he resides. They then reported
4 it to the South Eastern Trust, who began the
5 investigations with the Belfast Trust and the PSNI. 15:03
6 Unfortunately, when P118 was interviewed he did not
7 disclose enough detail about the sexual incident for
8 the investigation to move forward. I was updated via
9 phone call from the PSNI and The Belfast Trust. No
10 written correspondence was ever forwarded regarding the 15:03
11 position or outcome from either department.
12

13 I have essentially taken over as P118's next of kin
14 from my mother since the beginning of 2020 regarding
15 care related concerns within the facility of the place 15:04
16 that P118 currently lives. P118 was transitioned to
17 that place from Muckamore in May 2017 as his
18 resettlement in the community.
19

20 During this time, I have learned about the lack of 15:04
21 medical information and care needs that were not
22 disclosed to the new facility from MAH and The South
23 Eastern Trust. There have been numerous times during
24 care review meetings that P118's presentations have
25 been seriously misrepresented by either Trust staff or 15:04
26 the other facility staff.
27

28 What I heard and read during these meetings did not
29 describe P118. I believe it was describing a person

1 who had been failed by the State when seeking
2 professional assistance for their mental health, only
3 to be thrust into a world of mental, verbal, physical
4 and sexual abuse from within MAH. I believe the toxic
5 experiences within MAH gave P118 learnt behaviours, 15:05
6 something which he never had before entering MAH.
7 I also believe they misrepresented P118's true
8 personality and needs.

9
10 I have experienced very challenging times with the new 15:05
11 facility regarding P118's care. I believe a degree of
12 this was caused by MAH and their misdiagnosis of P118.
13 For example, elements of P118's care plans did not
14 support his needs relating to personal care and
15 consideration of P118's inoperable arteriovenous 15:05
16 malformation and neglect by the other facility who did
17 not follow through on set plans either.

18
19 I am upset about how P118 has been treated. His
20 current living situation is based on his behaviour but 15:05
21 I have never had any problems with P118's behaviour
22 when he has stayed with me or in my company. I believe
23 that the Trust has graded P118 unfairly and that the
24 behaviours he has exhibited were caused by the staff in
25 the Trust and their failure to treat P118 properly. 15:06
26

27 In terms of resettlement, the process has been very
28 frustrating. The resettlement facility should have
29 properly trained staff with knowledge of how to treat

1 people with learning disabilities, but they are no
2 fitter than anybody else to look after P118. Many of
3 the issues are environmental and sensory. The
4 resettlement facility is very depressing and this is
5 very difficult for P118. During Covid, P118 was
6 presented with his notice. His behaviour had become
7 extreme because he could not see his family in person.
8 This caused his behaviour to change and so the manager
9 phoned and said that she did not know what to do and she
10 was going to phone the police. This surprised me
11 because they are meant to be the experts but she did
12 not seem to have a clue what to do. I felt it was
13 inappropriate for her to even make that suggestion.
14 I am very disappointed that P118 is still there and it
15 has not worked out.

15:06

15:06

15:07

16
17 I believe what failures in P118's care began with lack
18 of leadership from every level of management within the
19 Belfast Trust and South Eastern Trust. I am upset at
20 how P118 has been treated. P118's current living
21 situation is based on his behaviours at MAH. I believe
22 that the Belfast Trust and South Eastern Trust graded
23 P118 unfairly and that the behaviours he has exhibited
24 were caused by the staff in MAH and their failure to
25 treat P118 properly.

15:07

15:07

26
27 MAH did not provide the adequate environment P118
28 required for his treatment plan. I believe that they
29 relied heavily on chemical control to manage P118 in

1 these unsympathetic environments. I never felt assured
2 or confident that MAH knew what they were doing.
3 I also feel the same way about the facility P118
4 presently resides in.

5
6 I feel traumatised by what has happened in MAH to P118.
7 I feel that I have neglected P118 letting him be in
8 this place and I feel guilty as a result. P118 is now
9 50 and he has heart failure. I want his situation to
10 be resolved as soon as possible so that he can live
11 happily for the rest of his life."

12
13 You then, if you turn over the page, give a declaration
14 of truth and sign your statement and there are no
15 exhibits to the statement. So P118's sister, having
16 heard me read that out, first of all are you content
17 that the contents of your statement are accurate?"

18 A. Yeah.

19 100 Q. would you like to adopt that as your evidence to the
20 Inquiry?

21 A. Yes.

22 101 Q. I'm not going to ask you to repeat everything that I've
23 just read out but there are a few issues that I just
24 want to ask you some additional questions about, okay.
25 And the first is about what P118's life was like in
26 Muckamore. You described him as being an active person
27 before going into Muckamore and you described he
28 particularly enjoyed cycling. What opportunities for
29 activity, and physical activity in particular, were

1 there whenever P118 was in Muckamore?

2 A. I believe that they had a swimming pool which [name] my
3 brother....

4 102 Q. Don't worry, we are just going to pause and we are
5 going to rectify the feed and the transcript. As I 15:09
6 said to you before, it is nothing to worry about, this
7 happens all the time. You just said there that you
8 understood that there was a swimming pool at Muckamore
9 and that you were going to tell us something about your
10 brother connected to that? 15:09

11 A. Yes, the swimming pool was available, I'm sure possibly
12 every day but it may have been a stage in [names
13 brother]'s life.

14 103 Q. Don't worry. Okay, as I said it might be easier just
15 to say "my brother". 15:10

16 CHAIRPERSON: Hold on a second. Just pop that in front
17 of the witness. I should have done this ages ago! It
18 just says "my brother" and it seems silly but it will
19 actually help.

20 A. Thank you. 15:10

21 CHAIRPERSON: Please don't worry, everybody has done it
22 .

23 A. I think probably because it is important because he is
24 a person.

25 CHAIRPERSON: Exactly, we totally understand that. 15:10

26 104 Q. MS KILEY: Okay. So the feed has started up again.
27 Can I ask you to start again at the swimming pool
28 please.

29 A. Yes, the swimming pool was made available to my brother

1 which would have been, to me, the only form of exercise
2 that my brother was introduced to. I don't believe
3 there was any other exercise introduced to him. That's
4 where family would have took my brother out for walks,
5 around the complex or out within facilities where we 15:11
6 felt he was able to enjoy those type of activities
7 where the ground was flat within a time period that
8 would have been appropriate to him that he could
9 obviously take part in that time period. Other than
10 that, I don't believe there was anything else offered. 15:11
11 I certainly wasn't advised of any other activities that
12 may have been offered.

13 105 Q. Do you know how often he would have used the swimming
14 pool?

15 A. No is the answer, and it wasn't for the entire time he 15:12
16 was in the hospital from 2009 to 2017, that was over
17 that period. How often I don't know.

18 106 Q. CHAIRPERSON: Can I just ask while we are on that, I'm
19 sorry to interrupt Ms. Kiley, but when he was living in
20 the community he could cycle. 15:12

21 A. Yes.

22 107 Q. CHAIRPERSON: Somebody would have to cycle with him?

23 A. No.

24 108 Q. CHAIRPERSON: so he could cycle on his own?

25 A. Yep. 15:12

26 109 Q. CHAIRPERSON: Quite safely?

27 A. Yes.

28 110 Q. CHAIRPERSON: And get himself back home.

29 A. Yes, yes.

1 111 Q. CHAIRPERSON: Until when?
2 A. Until it got too dangerous on the roads where it was
3 just unsafe for him to do so. Therefore, he then
4 stopped himself because he knew it was -- the gauge of
5 traffic. 15:13
6 112 Q. CHAIRPERSON: But in a safe environment he could have
7 cycled?
8 A. But in a safe environment, yes, he could have. As I
9 say, he could have maybe cycled 30 miles in a day if he
10 wished to do so, and had done. And again just giving a 15:13
11 bit of content, that was on a mountain bike with quite
12 a lot of gears to it and he done it in second or third
13 gear, which is a lot of pedalling, to go somewhere. So
14 there was a lot -- he was a fit man at the time, very
15 fit. 15:13
16 CHAIRPERSON: Thank you. Sorry to interrupt.
17 113 Q. MS. KILEY: That's physical activity. What about your
18 brother's access to other activities when he was at
19 Muckamore, did he attend day care facilities or
20 anything of that kind. 15:13
21 A. Yes, there was a separate building which was the
22 sensory needs building, as far as I am aware, that is
23 certainly what my brother referred to it as, and he
24 really, really enjoyed that, I think because, again it
25 was peaceful from the environment of the ward where he 15:14
26 could relax a little bit, get away from staff, other
27 patients, so much noise because the ward had really
28 high ceilings which noise echoed in and he wouldn't
29 have enjoyed those types of environments. But the

1 sensory room, I think I was in it twice myself, was
2 completely different and he enjoyed that, that was his
3 activity with regards to being on site. Staff would
4 have also have taken him out shopping into Antrim and
5 got a few bits and pieces as another activity. Maybe 15:15
6 that was a cross activity where you are gaining
7 exercise to walk to the building and also an activity
8 of purchasing personal items as well, but that was
9 really it.

10 114 Q. what about behavioural therapies? Did he ever receive 15:15
11 anything of that kind, to your knowledge?

12 A. what do you mean by that?

13 115 Q. So perhaps did he receive any therapeutic treatment
14 from a behavioural therapist or it might even have been
15 a psychologist, to your knowledge? 15:15

16 A. I am not aware that he ever received or was even
17 offered that.

18 116 Q. Okay. what about your brother's care plan? Did you
19 ever see a formal document of that kind whenever he was
20 in Muckamore? 15:15

21 A. Again, I personally wasn't shown a copy of that.

22 117 Q. I want to then move on to the next issue that I wanted
23 to ask you a little bit more about and that is from
24 paragraph 11 of your statement because you say there
25 that your brother would have regularly disclosed to you 15:16
26 that staff upset him and you give examples there about
27 staff. You say that he told you they would have
28 laughed, shouted, swore and punched him. Whenever your
29 brother made those disclosures to you, did you raise

1 the issues with staff at Muckamore?

2 A. Yes, I would have asked the staff who would have then
3 came and got my [name's brother] after....

4 118 Q. We'll pause the feed for a second. So I was asking you
5 whether, when your brother made disclosures to you, you 15:17
6 ever raised those or reported those to staff?

7 A. Yeah. When visiting was over, staff would have come to
8 escort [name's brother] -- sorry.

9 119 Q. So I asked you then about what would have happened
10 whenever your brother reported disclosures to you and 15:17
11 whether you reported those to anyone in Muckamore and
12 you were starting to tell me what would have happened
13 after visiting with your brother ended, so will you
14 tell us a bit about that?

15 A. Yeah, when staff came to receive my brother, I then put 15:18
16 to them what my brother had explained to me, and the
17 answer is either they didn't know because they hadn't
18 dealt with anything or they were unaware or they would
19 enquire from another member of staff what this incident
20 related to. And at times, nobody came back to me or 15:18
21 somebody did come back to me but they also weren't
22 aware of what had happened. I don't know if it was a
23 case maybe because of change in shift, timings that
24 they hadn't received a hand-over period for what had
25 happened that day, but everything seemed to be 15:19
26 dismissed, was the long and the short of it. You never
27 got any answers as to what actually happened to start
28 something off with [name's brother].

29 120 Q. Okay, so I'll ask you to continue what you were just

1 saying to me, you are saying you never got answers and
2 then you were about to continue?

3 A. Never got answers, it was always dismissed, it was
4 always dismissed.

5 121 Q. And when that happened, did you ever consider 15:19
6 escalating your concerns beyond staff at ward level?

7 A. Yes, I had thought about it, but as far as I was
8 concerned, I was taking it to the manager of the ward
9 for them to obviously come back to me as a concerned
10 relative which at times they would have obviously 15:20
11 spoken to me about different elements but again, they
12 maybe weren't on duty that day and they were speaking
13 from -- they were reading from notes that somebody else
14 had created. How accurate those notes were, nobody
15 will ever know and therefore at that point, because it 15:20
16 was ward level, on assumption, I thought I was speaking
17 to the right people about it.

18

19 I know that my mother had addressed different concerns
20 with the doctors in meetings who would have obviously 15:21
21 listened but kind of fed that back down the food chain
22 again to the management on the ward. So in respect,
23 kind of went round in circles when you had concerns,
24 which problems obviously still continued throughout
25 that. 15:21

26 122 Q. You referred there to meetings that your mother had
27 with staff at Muckamore. Do you know how often they
28 took place?

29 A. I can't actually say just how often, but meetings took

1 place when felt needed, really.

2 123 Q. And so was that the main method of communication
3 between Muckamore and your family?

4 A. Well, to discuss [name's brother]'s future, yes.

5 124 Q. Sorry, I will just pause you there. Okay, so I was 15:22
6 asking you about the meetings that your family had with
7 Muckamore and whether they were the main method of
8 communication between Muckamore and your family?

9 A. Yes, meetings took place to further his care. There
10 was also telephone conversations with myself and ward 15:22
11 staff. That also would have happened with my mother as
12 well talking to ward staff, plus face-to-face as well
13 whilst we would have been visiting.

14 125 Q. Did your family have a single point of contact within
15 Muckamore with whom you could raise concerns? 15:23

16 A. I didn't have, no, and there certainly wasn't any names
17 put forward to myself about that either. I don't
18 believe my mother had that either. It seemed to be
19 just whoever happened to be on duty.

20 126 Q. Were you ever provided with a complaints procedure in 15:23
21 respect of the hospital to tell you how to raise
22 concerns?

23 A. Again, I wasn't.

24 127 Q. Another issue that I want to ask you about is the 15:23
25 incident that you talk about at paragraph 17 and 18 of
26 your statement, you describe a particular incident
27 there and you say that P118 was interviewed by the PSNI
28 in respect of that, and you then refer to being updated
29 via phone call from the PSNI and the Belfast Trust

1 after that. I just wanted to clarify that in your
2 mother's statement, your mother said that the family
3 wasn't told about the outcome of the investigation.
4 Can you just clarify what you were told about the
5 outcome of the investigation after that interview? 15:24

6 A. Yeah, as stated, the PSNI contact for that particular
7 investigated had made a call to myself to explain the
8 outcome, which unfortunately came to a dead end, and
9 from the Belfast Trust there was also a phone call but
10 no written report from either PSNI or the Belfast Trust 15:25
11 to deliver a closing report from either came through,
12 it was just verbal phone call.

13 128 Q. As far as you are aware, is there any ongoing police or
14 Trust investigation into that matter then?

15 A. No. 15:25

16 129 Q. No, okay. One of the things that you referred to a few
17 times in your statement is what you described as an
18 issue with the leadership at Muckamore and particularly
19 at paragraph 7, you said that you felt the leadership
20 was not there to ensure that staff were able to deal 15:25
21 properly with your brother, and I wanted you to ask you
22 to elaborate on what you mean by that, if you can.
23 what did you think that the leadership needed to be
24 doing to be able to deal properly with your brother?

25 A. Well, that's exactly it, it's the leadership. You had 15:26
26 a doctor who seemed to be answering [name's brother]'s
27 care with...

28 130 Q. I'll just stop you there. Don't worry, we will pause
29 the transcript. Okay, so you were telling us what you

1 meant about the issues about leadership at Muckamore?

2 A. So you had doctors who were managing the situation
3 through drugs. Then, as far as I am concerned, the
4 next management was the ward staff and those positions
5 within that. They were obviously being directed from
6 the doctor's, I suppose the doctor's view with the use
7 of medication, because it took some years before
8 [name's brother] was given -- sorry.

15:26

9 131 Q. If we just pause. Okay, if I can ask you to pick up
10 there, please.

15:27

11 A. So it was some years before my brother was given a one
12 to-one for support and I questioned it with the
13 leadership how could he have spent so long in a place
14 when nobody was taking responsibility to look at his
15 care to see exactly, well, what is it that this chap
16 really needs? Is it all this medication? Is it? And
17 it's not taking responsibility, nobody was coming
18 forward with any great plans. He was just existing in
19 the place, day after day after day after day, and it
20 seemed to be nobody wanted to take responsibility of
21 trying something different away from all these drugs
22 that seemed to be given to him. The leadership again,
23 the staff taking responsibility, not taking
24 responsibility, depending on the day who was actually
25 managing the ward, or at night as well, and staff doing
26 double shifts with little rest time in between, people
27 become fatigued, they are not necessarily managing
28 properly, which then is a knock on effect to their
29 leadership skills.

15:28

15:28

15:29

1 132 Q. And those issues that you're describing, were they a
2 feature for your brother's period in Muckamore the
3 whole time that he was there or was there particular
4 time that you felt that that was evident?

5 A. Certainly after the first year, nothing seemed to be 15:29
6 changing after 12 months, and that continued that
7 nothing changed up until the point where change was
8 coming in via government....

9 133 Q. There was a partial name.
10 CHAIRPERSON: You just stopped yourself! 15:30

11 A. I'm learning.

12 134 Q. MS. KILEY: Okay. You were describing to me then when
13 you felt that the issue that you have been talking
14 about was particularly evident. If you could pick up
15 with that please? 15:30

16 A. Yes, where he was being asked to basically move out of
17 Muckamore to the community. Again, some people may say
18 that leadership was highlighted there. However,
19 pressures from the government were put on those, in
20 those leadership positions to actually be a leader and 15:31
21 do something, and all of a sudden my brother was then
22 able to be on a programme for resettlement but I don't
23 understand why he had to be in the hospital for eight
24 years, I don't understand that whenever he had his home
25 to return back to. 15:31

26 135 Q. And you're saying there you don't understand why that
27 was the case. Did anyone at the hospital ever explain
28 to you why your brother was in Muckamore for the time
29 period that he was?

1 A. No.

2 136 Q. One of the things that you mentioned there before you
3 were talking about your brother's move out of Muckamore
4 was what you described as his management by drugs
5 within Muckamore and in your statement, you refer to 15:31
6 the use of PRN in particular, so. I want to ask you a
7 little bit about that. Are you able to say how often
8 your brother was given PRN during the period in
9 Muckamore? Was it a regular occurrence? Irregular?

10 A. Yeah, it seemed pretty regular. There was a period 15:32
11 maybe about 2015-ish, give or take, where each time
12 that we had been visiting [name's brother]...

13 137 Q. If we could stop the feed, please. Okay, if I could
14 ask you to pick up. I was asking you about how often
15 you might have noticed PRN being issued? 15:32

16 A. Yeah, there was a time that every visit he was heavily
17 drugged.

18 138 Q. Why do you say that? What way was he appearing that
19 made you think that that was the case?

20 A. As I had stated, his eyes rolling in his head, slurred 15:33
21 speech, tripping over his own feet, couldn't really
22 stay awake whilst we were in his company, while we were
23 trying to have a conversation, and if he was able to
24 interact that day, he was probably trying to explain to
25 me an incident that had obviously happened that day, or 15:33
26 maybe the night before, because usually with my
27 brother, it's like a 24 hour sort of cycle with the
28 trauma he would receive from an incident, regardless of
29 what the trigger may have been. So if my brother had

1 an incident the night before and was quite upset going
2 to bed, he may have been given medication then to
3 settle him. The next day, he may have awoke still
4 quite annoyed with what happened the evening before, or
5 the day before, and still would have been quite upset 15:34
6 therefore, again on assumption another dose of PRN may
7 have been administered at that point, or it may not,
8 but regardless, it was incidents that seemed to trigger
9 this extra medication coming in.

10 139 Q. Okay. Are you saying there was, to your knowledge, 15:35
11 specific incidents that resulted in the administration
12 of PRN?

13 A. Yes.

14 140 Q. How did you know about that? were staff telling you
15 that incidents occurred and they needed to administer 15:35
16 PRN?

17 A. Nobody, nobody actually informed me of different
18 incidents. My brother informed me because he can
19 communicate very well and knows when someone has been
20 unkind to him. Therefore, he would then challenge the 15:36
21 situation, hence then the knock-on effect that came
22 from that. He may have presented his behaviour in a
23 way that staff deemed unsuitable, but suitable to
24 administer PRN to again resolve the situation.

25 141 Q. Did your family ever raise concerns about the use of 15:36
26 PRN with staff at Muckamore at those times?

27 A. I didn't with the term PRN but I had mentioned it to
28 different staff over that period of time that that
29 [brother's name]....

1 142 Q. Okay. I asked you if you raised any concerns about the
2 use of PRN with staff at Muckamore?

3 A. Again, bearing in mind this was verbal, this was
4 face-to-face, there was nothing in writing of any sort,
5 so it was who was ever on duty on a particular day that 15:37
6 I had mentioned that [brother's name] -- sorry.

7 143 Q. That's okay. Stop the feed again please. Okay, so I was
8 asking you about the reporting of any issues with PRN
9 PRM and you were saying that it was verbal, is that
10 right? 15:38

11 A. Verbal, yep. That he appeared very drugged. They took
12 that on board. As I say they gave some explanation to
13 whatever that was. I obviously had a conversation
14 about that back with them again, but they seemed to be
15 well educated in giving the answers that you could say 15:38
16 fob people off to the extent where that medication was
17 needed. You know, "you weren't here at the time
18 whenever it happened; we were, we had to deal with it,
19 this is how we dealt with it. Medication was given."

20 144 Q. And you described various outings that you would have 15:38
21 taken your brother on outside Muckamore. Would he ever
22 have needed PRN or medication during those sorts of
23 events and outings?

24 A. Never. He has never needed any additional medication
25 whilst in the company of his family, that's then, and 15:39
26 currently he never needs that. I never have any
27 problems with my brother, ever.

28 145 Q. Okay. And he is now in his new resettlement facility
29 as we have been calling it. How is he getting on

1 there?

2 A. That was reasonably fine from his transition in 2017
3 until 2019. They have problems, management problems as
4 well, which was a knock-on effect to his care. They
5 couldn't get managers in a permanent position there for 15:40
6 approximately I think it was maybe two years, two and a
7 half years, so there is a lot of change within that
8 facility and it was very challenging, to say the least,
9 and accepting what [names brother]'s needs -- sorry.

10 146 Q. Okay, you were just explaining there was a period when 15:40
11 it was very challenging when [names
12 brother]...(interjection)

13 CHAIRPERSON: You have just done it now!

14 147 Q. MS. KILEY: Oh, I am sorry. So you were explaining
15 about the challenging period whenever your brother 15:41
16 moved to the new facility.

17 A. Yes, simply because of their own management issues and
18 problems came then a knock-on effect then with [names
19 brother]'s care.

20 148 Q. Okay, so can you tell us again about the challenges 15:41
21 that you want to tell the Panel about?

22 A. Yeah, with the care provided in his current, in his
23 current respite.

24 149 Q. His placement?

25 A. Whichever you wish to call it, he had a lot of -- a lot 15:42
26 of trouble really from 2019 onwards, roughly to about
27 2021, middle of 2021, I took over a lot of that
28 responsibility from the beginning of 2020 because there
29 was just numerous things that were starting to -- duty

1 of care was starting to slip and general cleanliness
2 about the place. The food types that were being
3 offered to my brother was poor. They were offering
4 food types to him that suited them but not suited his
5 needs. So that meant that he was eating or trying to 15:43
6 eat foods that he didn't like. Therefore, he reverted
7 to negative snack foods, and still does because it's
8 learnt behaviour now, that when he left Muckamore he
9 was query query Type 2 diabetes now, he is full blown
10 because he has had so many opportunities of consuming 15:43
11 negative snack foods through learnt behaviour of that
12 time 2019 into 2021 where he could do that to survive.
13 He was smart enough to know that, well, if you are not
14 giving me the foods that I need to eat I know I have
15 snack foods and I can survive on that, which is really 15:44
16 sad.

17 150 Q. CHAIRPERSON: Could I just ask about that? Were these
18 preferences in terms of food? So was it things he just
19 didn't like to eat or were there specifics things that
20 he found physically difficult to eat? 15:44

21 A. Both. I believe he was being offered like Chinese
22 style cooking, like rib-type foods which wouldn't be to
23 his taste or to chew as well because that is a big
24 factor, problematic where he can choke, and has done as
25 well. 15:45

26 151 Q. CHAIRPERSON: So it wasn't simply preference; it was a
27 physical difficulty?

28 A. Yes.

29 152 Q. CHAIRPERSON: Was there a diet plan or a food plan for

1 him?

2 A. At the time, I'm unaware that they had even considered.

3 153 Q. CHAIRPERSON: To be fair, you don't know, but I think
4 probably the high point you can say is you never saw
5 one if there was one? 15:45

6 A. No, I'm told that menus were created but when you
7 analyse the menus, they are based around what you
8 believe someone may like or enjoy, not the types of
9 foods my brother would have been used to; i.e. he
10 enjoys porridge, he enjoys salads of any meat selection 15:46
11 to them. He enjoys proper dinners; vegetables,
12 potatoes, meat, he enjoys all of that. Really good
13 with vegetables and salads but yet was being offered
14 foods that were not familiar to him to even know what
15 they were. If you use the word "fajitas", he would not 15:46
16 understand what that is, but if you explained that it
17 had the types of ingredients, he would understand then,
18 but make it plain, so.

19 154 Q. MS. KILEY: Can I just clarify with you on that, was
20 your brother seen by a dietician whenever he was in 15:47
21 Muckamore?

22 A. I believe he was, yes.

23 155 Q. Okay. And you used a phrase in answer to my question
24 earlier, you said that your brother is displaying
25 learnt behaviours. What do you mean by that? You 15:47
26 referred to them as I think learnt behaviours from
27 Muckamore so what are those learnt behaviours?

28 A. Well, he understands that to get something -- he
29 understands to get something what he needs to do. So

1 if, for example, the presentation of the food within
2 his current living arrangement isn't what he is
3 enjoying or would like, he has learnt survival skills
4 from being in Muckamore through the experience he has
5 experienced through that, of how to survive now whilst 15:48
6 in the hospital, he had picked up these behaviours that
7 he had never displayed before going into hospital. So
8 where he picked them up within the hospital, I don't
9 know, because I wasn't there, but he had to learn how
10 to survive and some of these behaviours were also a cry 15:48
11 for help as in, if I do something so severe that
12 someone will listen to me or see what's happening or
13 I'll be able to leave this ward for at least a day or
14 two, or maybe a week, just to get out of it. So you
15 learn from watching and observing others do things or 15:49
16 say things that he has picked up on that and then
17 implemented that himself.

18 156 Q. Okay. P118's sister, I don't have any other issues
19 that I want to ask you specifically about. It maybe
20 that the Panel have some questions for you? 15:49
21 CHAIRPERSON: Professor Murphy.

22
23 P118'S SISTER WAS THEN QUESTIONED BY PROFESSOR MURPHY.

24
25 157 Q. PROFESSOR MURPHY: It sounded like in 2009 you had a 15:49
26 good plan for your brother's long-term care, i.e.
27 a family house with supported living and you tried to
28 put that supported living in yourselves. Did you talk
29 to social workers about the possibility of staff

1 support to do that, so that it wasn't entirely on your
2 family?

3 A. That was the whole point, that my brother had his own
4 home to go back to, there was always a building there.
5 PROFESSOR MURPHY: Yes. 15:50

6 A. And for others. It was being opened up to others, it
7 wasn't just about him, to view the bigger picture here.
8 For that to work, there needed to be a care package
9 present to allow that to work. That had been -- my
10 mother had presented that to the social workers at the 15:50
11 time who immediately reneged on that as stated, that
12 that would be something they believed that wouldn't
13 work. What that actually means, I don't know, because
14 that wasn't clarified and I think the conversation
15 wanted to be shut down because it didn't tick the box 15:51
16 of how things were done as opposed to maybe what
17 [name's brother]'s needs were.

18 158 Q. MS. KILEY: Sorry, if we stop the feed please. Okay,
19 we are ready to go again. You were answering Professor
20 Murphy's question. 15:51

21 A. So my brother's needs, from the family's perspective,
22 were overlooked because there was a building there for
23 him and for others. There was an opportunity, or
24 opportunities, as I say, for not just my brother but
25 for others with the right support from the South 15:52
26 Eastern Trust to consider that further but that wasn't
27 and....

28 159 Q. PROFESSOR MURPHY: So they never said to you for
29 example, let's give it a try or?

1 A. No.

2 160 Q. PROFESSOR MURPHY: Or give you any particular reason
3 why it couldn't happen?

4 A. Just the fact that they believed, which is kind of a
5 throw-away comment, "believed". It wouldn't work for 15:52
6 him because they couldn't justify putting a whole team
7 of staff there just for my brother, it would need to
8 accommodate other people, which wasn't a problem. They
9 had suggested that my brother wouldn't cope well if
10 there was others within the building but there is lands 15:53
11 at the side of the house at the time, there was
12 opportunity for extensions, a bigger build to
13 accommodate that, that it could have been several
14 separate buildings, but all interlinked perhaps to
15 again accommodate, but they didn't want to know. 15:53

16 PROFESSOR MURPHY: Okay, thank you.

17 CHAIRPERSON: When you were talking about I think the
18 topic you were discussing was leadership, you said
19 there came a time when it took a while to get
20 one-to-one support for your brother and I just want to 15:54
21 understand that a bit; how long was he in Muckamore
22 before he got one-to-one support and what difference
23 did that make?

24 A. That, I think that came, the one-to-one support came
25 whenever he had swallowed the batteries. Again, 15:54
26 I believe that my brother done that to escape the
27 hospital ward, to get out, cry for help. When he came
28 back into Muckamore again, from Antrim Area Hospital,
29 as a family we were obviously very concerned. My

1 mother asked for a meeting with the consultant at the
2 time where it was suggested that the way around this to
3 assist that a one-to-one was there to help.

4 161 Q. CHAIRPERSON: And that happened?
5 A. Yes. 15:55

6 162 Q. CHAIRPERSON: Did that help him?
7 A. Yes, to an extent, to an extent, depending who the
8 person was.

9 163 Q. CHAIRPERSON: Yes, of course, okay.
10 A. If there was a good personality match, perfect but 15:55
11 there would have been numerous staff that were not.

12 164 Q. CHAIRPERSON: Yes, all right. All right. Can I thank
13 you both, if I can address you both, for coming along
14 to tell us about your brother and your son and you've
15 done so, if I may say so, in very moderate terms which 15:56
16 has helped us a lot, you have been very factual about
17 it and that has helped. So can I thank you both very
18 much for what must have been a difficult experience, we
19 understand. All right, thank you.

20 MS. KILEY: Chair, we do have another witness coming. 15:56
21 I am being asked could we take a five minute break.
22 There are issues that this witness -- there maybe
23 something to be dealt with, there may not, but if there
24 is, if we could take a break I can update you at the
25 you the set of the next session. 15:56

26 CHAIRPERSON: Sure. Well, what we will do is we'll
27 take a 10 minute break, I think, and then you can speak
28 to the secretary of the Inquiry to see if there is
29 anything that you want to add. Is that all right?

1 Thank you very much.

2

3 THE HEARING ADJOURNED FOR A SHORT PERIOD.

4 THE HEARING THEN RESUMED AS FOLLOWS:

5

16:12

6 CHAIRPERSON: Thank you.

7 MS. KILEY: Chair and Panel members, you will see that
8 P118's mother is back at the witness table. whilst
9 listening to P118's sister give evidence, there were
10 two other matters that P118's mother remembered that
11 she would particularly like to bring to the Panel's
12 attention.

16:12

13 CHAIRPERSON: Absolutely, okay.

14

15 P118's MOTHER GAVE FURTHER EVIDENCE AS FOLLOWS TO THE
16 INQUIRY:

16:12

17

18 165 Q. MS. KILEY: So P118's mother, as you know, we are going
19 to refer to your son as P118, or your son, and is it
20 right that in listening to your daughter give evidence
21 there were two matters that you wanted to raise with
22 the Panel?

16:12

23 A. Yes.

24 166 Q. And the first was in relation to the incident that you
25 have already described at paragraph 37 of your
26 statement, isn't that right?

16:13

27 A. Yes.

28 167 Q. You have that in front of you. This relates to the
29 time where in and around 2014 and 2015, your son was in

1 Antrim Hospital and at paragraph 37 there you have
2 already said that whenever your son was discharged from
3 Antrim Hospital you requested an interview with
4 Dr. H40, your son's consultant?

5 A. That's correct. 16:13

6 168 Q. In listening to your daughter give evidence, there was
7 something else that you remembered about that. Do you
8 want to tell the Panel what that was?

9 A. Yeah, I brought it to the attention of H40 on that
10 interview that Muckamore Abbey Hospital didn't have 16:13
11 medical cover at night, which I thought it was
12 appalling.

13 169 Q. What do you mean by "medical cover"?

14 A. A doctor. And one of the reasons why my son wasn't
15 admitted to Antrim Area Hospital until the morning of 16:14
16 the evening that he took ill, was very ill with the
17 inflammatory situation with swallowing the batteries
18 was because there wasn't a doctor there to see him
19 until the morning.

20 170 Q. That was on the separate occasion that you have 16:14
21 referred to in your statement?

22 A. Yes. H40's reply to that was that there was an ongoing
23 meeting, he said, and one coming up very soon which he
24 invited me to attend which they were going to discuss
25 that they would bring that forward in terms of having a 16:14
26 medical officer on Board, certainly in the evenings.
27 I didn't attend that meeting because it wasn't suitable
28 for me on the day, because I still work, and so I
29 didn't get to hear the whole layout of that, but about

1 three months later I was aware at visiting time that a
2 locum doctor was on duty from eight o'clock to eleven
3 and I was then told that that was in situ.

4 171 Q. So there was then medical cover from eight o'clock?
5 A. From eight o'clock to 11:00 when patients who were 16:15
6 displaying some sort of illness, that that doctor was
7 there, he just stayed in a room off the reception area
8 and the patients would have been brought from any of
9 the wards, but it was based in Cranfield 1.

10 172 Q. Okay. And to your knowledge that was 16:16
11 ...(interjection)?

12 173 Q. DR. MAXWELL: Can I just clarify you are talking about
13 resident medical cover? There would have been medical
14 cover off site that the nurses could call but you're
15 talking about resident medical cover? 16:16
16 A. Yes.

17 174 Q. MS. KILEY: The second issue then that you wanted to
18 reply to was the Chair's question to your daughter
19 about resettlement of your son and in exchanges, there
20 was a discussion about how long it took for your son to 16:16
21 move out of Muckamore and I know you wanted to say
22 something about that?

23 A. Yeah, yeah. well, they did have and did hold and I
24 attended every one of those progress meetings that they
25 called and there would have been maybe 12 people from 16:16
26 the Trust, ward staff, the consultant as well, and at
27 every progress meeting, all we heard was that there was
28 no finance available to resettle [name's son].

29 175 Q. So you were telling me there that you attended all the

1 progress meetings in relation to proposed resettlement
2 and you were about to tell me something about what was
3 discussed about finance?

4 A. Yes, finance seem to be a big problem until Stephen
5 Nolan from BBC decided he was going in and made an 16:17
6 issue out of the -- because it had been brought to his
7 attention that there were numerous patients in there
8 who had been there for many, many, many, many years,
9 a lot of them died in there as well. So at that time,
10 H40 told me that money had been thrown at them, and 16:18
11 that's the words he used to me, thrown at them to get
12 patients out of Muckamore Abbey Hospital.

13 176 Q. What time period would that have been?

14 A. Year?

15 177 Q. Yes, if you can, roughly. 16:18

16 A. That was probably three or four years before [name's
17 son]'s discharge.

18 178 Q. Okay, so I just asked you to clarify the time period
19 for that, and you are telling me it was three or four
20 years before your son's discharge, is that right? 16:18

21 A. Discharge, yes.

22 179 Q. And are those all the issues that you wanted to raise
23 with the Panel, the additional issue that came to you
24 when listening to the evidence?

25 A. Yeah, with Muckamore Abbey Hospital anyway, yes. 16:19

26 CHAIRPERSON: Okay. Well, again thank you for coming
27 back and thank you for giving us that additional
28 information. Thank you both again and you can now go
29 with Jaclyn, that completes your evidence to the

1 Inquiry.

2 A. Thank you. Could I just take this opportunity not only
3 on behalf of ourselves, as my son's family, to thank
4 everyone involved in this Inquiry. It's meant so much
5 to so many people and also to people whose relatives 16:19
6 who have passed away, whose relatives are passed away
7 too, and I have to say that just a few months before it
8 all was exposed, certainly on the BBC, I actually one
9 day, and I have to tell you all this, one day I was
10 coming away from visiting my son from that hospital and 16:20
11 on the way past the main offices, I said a prayer and I
12 said: "Lord, I would love that this was exposed, what
13 goes on in this institution here." And the evening --
14 I just happened to be in my kitchen when it came on the
15 BBC about the Inquiry and tears were literally running 16:20
16 down my face, because I felt that prayer was answered.
17 Yes. So it's....

18 CHAIRPERSON: well, thank you.

19 A. So I just wanted to say thank you for listening because
20 that has been so important to everybody, to all 16:20
21 families.

22 CHAIRPERSON: well, thank you very much indeed for
23 those kind words and we hope that at least some of your
24 prayers are answered, all right.

25 A. Thank you. 16:21

26

27 THE WITNESS THE WITHDREW.

28

29 MS. KILEY: Chair, the next witness is here and is

1 ready to proceed, Mr. McEvoy is taking that evidence.
2 CHAIRPERSON: Okay. Where is Mr. McEvoy?
3 MS. KILEY: He's just outside.
4 CHAIRPERSON: Right, lets get him in. I'm not going to
5 rise as it will take another minutes so we will wait. 16:21
6
7 Mr. McEvoy, welcome back to the hot seat, as it were.
8 Are you ready for the next witness?
9 MR. MCEVOY: Certainly are, Chair.
10 16:22
11 P8'S MOTHER HAVING BEEN SWORN WAS EXAMINED BY MR MCEVOY
12 AS FOLLOWS:
13
14 CHAIRPERSON: If we can just identify who we have got
15 in the witness box. 16:22
16 MR. MCEVOY: So Chair/Panel this afternoon, the final
17 witness the Inquiry will hear from, is mother from P8.
18 The Inquiry heard P8's mother's statement on the 26th
19 of September when I read it into the record and the
20 Inquiry and Core Participants will recall that P8's 16:22
21 mother was unwell and unavailable through illness on
22 that occasion and she is now....
23 CHAIRPERSON: Yes, what we wanted to do -- I am going
24 to call you P8's mother, I'm afraid, is to give you the
25 opportunity of saying really anything that you wanted 16:23
26 to, but you know that your evidence has been read in.
27 Were you well enough to watch that or not?
28 A. No.
29 180 Q. CHAIRPERSON: No. But you know your statement, of

1 course.

2 A. Yeah.

3 CHAIRPERSON: All right. Well, I will hand you over.

4 MR. MCEVOY: P8's mother, welcome along and there are
5 may be a few matters that you can clarify arising from 16:23
6 your statement. As you know, it has been read in. The
7 first of those relates to what you have told the
8 Inquiry in your statement at paragraph 26 and
9 hopefully, we will help you find it. I'll check on this
10 point, in this paragraph you tell us about a meeting up 16:24
11 at Muckamore on 23rd of June 2012 and if you recall the
12 circumstances of it, it was a visit in fact with your
13 son, you weren't allowed to take him to the Cosy Corner
14 on that occasion and you described then being "herded
15 like cattle" into a small visitor's room and treated 16:24
16 like criminals, you felt, not allowed to open the
17 window, the blinds or the door and you were told that
18 the reason for that was you were not allowed, the
19 background to it that there had been an issue between
20 your son and another patient. No eye contact was 16:24
21 allowed and you didn't know the nature of the
22 allegation. You said the room was very stuffy and
23 there were about nine people in it. Now the simple
24 point to be clarified there is can you remember, is
25 that the right number of people who were in the room? 16:25

26 A. No, seven.

27 181 Q. Thank you.

28 CHAIRPERSON: Because that is what was said in the
29 exhibit, I remember this. Thank you.

1 MR. MCEVOY: Yes. A small but no doubt important point
2 and the Inquiry likes to be accurate about everything.
3 And on that same score then, in terms of accuracy,
4 turning to paragraph 38 which is on page 15. Just to
5 set this particular topic in context here, you talk
6 about, and we will come back to it in a moment, the
7 Mental Health Review Tribunals and your efforts to get
8 representation and assistance in order to get your
9 son's detention examined by the Review Tribunal. At
10 paragraph 38 you say that:

16:25

16:25

11
12 "None of the staff in Muckamore advised me of the
13 advocacy service available to parents and families
14 offered by Bryson House. I only became aware of this
15 by speaking with another patient's mother in the Cosy
16 Corner at some stage..."

16:26

17
18 And you say in your statement: "...during 2016." Is
19 there any correction you want to make to that?

20 A. Yeah, it should have been 2015.

16:26

21 182 Q. Okay. Well, thank you.

22 A. Thank you.

23 183 Q. So I just have a very small number of questions arising
24 out of what is a very comprehensive and helpful
25 statement. Turning to page 23, I'm not going to take
26 you through this document, which is about five pages in
27 length, but turning to page 23 is a letter dated the
28 16th of August 2012. Okay, you have that in front of
29 you all right?

16:26

1 A. Yep.

2 184 Q. And it's a letter to Mr. Convery at the Mental Health
3 and Learning Disability Team in the RQIA. And in that
4 letter then, and over the following pages, you set out
5 all of the issues that you were experiencing. Did you 16:27
6 write that letter yourself or did you have any
7 assistance?

8 A. No, I wrote that myself. My sister helped me type it
9 up but I wrote it out to them.

10 185 Q. Okay. And then there is a response, turning to page 16:27
11 41, dated the 28th of August 2012 and it's from Teresa
12 Nixon, who is the Director of Mental Health and
13 Learning Disability and Social Work at the RQIA. She
14 says:
15
16 "I am concerned about the serious matters you raised in
17 your correspondence. RQIA have written to the Chief
18 Executive of the Belfast Trust seeking clarification in
19 respect of a number of matters and assurance about the
20 actions the Trust in relation to the safeguarding and 16:27
21 protection of your son and other residents as referred
22 to in your letter. I wish to assure you that the RQIA
23 will follow up with the serious matters you have
24 brought to our attention as matter of priority."
25
26 And you are given a contact as well. So that was the
27 28th August 2012. Did you hear from the RQIA after
28 that?
29 A. Not after that, no. 16:28

1 186 Q. No?
2 A. No.
3 187 Q. Finally then, just on the question of -- so we touched
4 on a moment ago the Mental Health Review Tribunal,
5 there were two attempts, as you describe in your 16:28
6 statement, to get your son out of the detention, the
7 first was in 2013?
8 A. Yeah.
9 188 Q. Had you any assistance of any description during 2013
10 effort to help you with representation to the Mental 16:28
11 Health Review Tribunal?
12 A. I had a solicitor. A solicitor with me, yep, that was
13 it.
14 189 Q. Okay. And no other form of advocacy or any input like
15 that? 16:29
16 A. No, I didn't. No.
17 190 Q. Okay, and then in 2015 can you tell us about any change
18 in the interim?
19 A. Yes, I had, as I stated on my thing, Bryson House.
20 191 Q. Yes. 16:29
21 A. And that opened doors.
22 192 Q. Okay. And can you tell us a bit more about that?
23 A. He explained the whole situation about the tribunal and
24 where it goes from start to finish, what evidence I
25 needed, you know, put me through the whole -- and made 16:29
26 me more relaxed, you know, took word for word for
27 everything like, you know, he got me where I am today,
28 do you know, my son out.
29 193 Q. Yes. And having access to that type of advocacy

1 service, we can take it was important in that process
2 and what would you say about your experience perhaps
3 for others in a similar position to you as a mother
4 with a patient in Muckamore?

5 A. They should be informed of your loved ones going in, do 16:29
6 you know what, who is there for help, who can guide you
7 through it, who can give you advice.

8 194 Q. You have described in your evidence, you have described
9 it in your evidence, it was sheer luck?

10 A. Yep, that I was talking to that mother, yep. 16:30

11 195 Q. I mean, in your view as a mother, clearly I think I
12 know what the answer to this question might be, but is
13 that an acceptable way to communicate?

14 A. No.

15 196 Q. All right. And then just in terms of the process 16:30
16 itself around the Mental Health Review Tribunal, you've
17 included some documents. One of those is a report from
18 one of the psychiatrists, who is H50, and if you can
19 find that at page 58. Okay. So it's really just so
20 that everybody else knows what document I am talking 16:31
21 about, but this is a medical report that was prepared
22 in relation to your son by the Clinical Director, who
23 has described himself as the Designated Risk Manager.
24 During that process, running up to the Mental Health
25 Review Tribunal, were you consulted with -- did the 16:31
26 Clinical Director or any other psychiatrists or the
27 clinical team speak to you about what they might be
28 putting into their report?

29 A. No, no, I just learned on the day.

1 197 Q. Well, that was my next question; what kind of notice
2 did you get?
3 A. Just learned on the day.
4 198 Q. Of that report and what it said in it?
5 A. No, I just learned what was all said on the day. I was 16:31
6 given your date, and, do you know, that's all.
7 199 Q. Yes. So you got notice of when the review tribunal was
8 going to take place?
9 A. Yes.
10 200 Q. But you didn't actually get sight of the report until 16:31
11 the day?
12 A. Didn't hear anything until the day, until I was in the
13 room.
14 201 Q. And therefore, there was no opportunity to get a second
15 opinion or anything of what was in the report? 16:32
16 A. No.
17 202 Q. All right. That's very helpful. Can I just ask you how
18 your son is getting on now? I know you tell us in the
19 statement but it's always nice to hear first-hand?
20 A. Yes, he is doing well, a bit of health issues, but he's 16:32
21 getting on, he's blooming.
22 203 Q. He has been out since 2017 and he is at home with you?
23 A. He is indeed.
24 204 Q. And it's working well?
25 A. Yes. 16:32
26 205 Q. Those are my questions, P8's Mother.
27 A. Thank you very much.
28 206 Q. There maybe something from the Panel, thank you.
29

1 P8'S MOTHER WAS QUESTIONED BY THE PANEL AS FOLLOWS:
2
3 207 Q. CHAIRPERSON: No, I have only got one thing; the
4 letter that you were referred to, to the RQIA of the
5 16th of August, and you have got that at page 23, 16:32
6 that's a five page or a six page letter and do you
7 remember you set out a series of concerns that you had
8 in that letter and then you got a response on the 28th
9 August and are you saying that's the only response you
10 got? 16:33
11 A. Yep.
12 208 Q. CHAIRPERSON: Did you follow it up.
13 A. I did, I asked when I went up to visit, I visited my
14 son three/four times a week and I kept asking was there
15 any, because I knew that [name's son] had told me. 16:33
16 CHAIRPERSON: Okay, we're just going to pause for a
17 second, you've done very well so far. Yes.
18 A. After my son informed me that RQIA was in the building
19 and I had asked them, I knew that RQIA had visited the
20 ward so I started asking was there any reports, was 16:33
21 there any...?
22 209 Q. CHAIRPERSON: Sure, but you didn't follow up with the
23 RQIA?
24 A. No. No.
25 210 Q. CHAIRPERSON: And you didn't get anything else from the 16:33
26 RQIA?
27 A. No, just that letter to say that they received my
28 letter.
29 CHAIRPERSON: Thank you very much indeed. Thank you

1 for coming back. Thank you for making your original
2 statement. I'm sorry you weren't well enough to come
3 and assist us on the day but I'm glad you have had the
4 opportunity now to adding those couple of
5 clarifications. 16:34

6 A. Thank you for closure. Thank you very much.
7 CHAIRPERSON: I understand. Anything else?
8 MR. MCEVOY: No, just my directions in relation to
9 tomorrow.
10 CHAIRPERSON: Right, thank you very much if you would 16:34
11 like to go with the secretary to the Inquiry.
12

13 THE WITNESS THEN WITHDREW
14

15 CHAIRPERSON: Tomorrow, we're not attempting a 9.30 16:34
16 start, are we?
17 MR. MCEVOY: I think that's right.
18 CHAIRPERSON: We are or we're not?
19 MR. MCEVOY: Are we?
20 CHAIRPERSON: My understanding is tomorrow we are 10 16:34
21 o'clock.
22 MR. MCEVOY: 10 o'clock.
23 CHAIRPERSON: I will just check with the Secretary to
24 the Inquiry. Jaclyn, tomorrow we are 10 o'clock?
25 MS. RICHARDSON: Yes. 16:34
26 CHAIRPERSON: Okay.
27 MR. MCEVOY: I am the late shift again tomorrow.
28 CHAIRPERSON: We will try and sit at 10, I do apologise
29 again for getting everybody here at half past nine.

1 My frustration, I assure you, is as great as yours.
2 All right, thank you very much indeed, see everybody
3 tomorrow at 10 o'clock.
4

5 THE HEARING ADJOURNED UNTIL TUESDAY, 10TH OCTOBER AT
6 10.00 A.M.

16:35