

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

HEARD BEFORE THE INQUIRY PANEL
ON WEDNESDAY 20TH SEPTEMBER 2023 - DAY 58

58

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THE INQUIRY RESUMED AT 10:00 A.M. ON WEDNESDAY, 20TH
SEPTEMBER 2023 AS FOLLOWS:

CHAIRPERSON: I'm sorry to everybody for the late start. Can I just say it is important that witnesses are here, available to Inquiry counsel, for 30 minutes before they give evidence. That's partly because all of these witnesses are going to find the experience difficult. They need to settle down and not be rushed through the door, as it were. Please can I ask, from now on, you make sure witnesses are here in the Inquiry building, available to the inquiry counsel, for 30 minutes.

Yes, Mr. McEvoy.

MR. McEVROY: Morning, Chair, morning Panel. Chair, before we proceed this morning, there is a preliminary issue. You will this morning hear from the sister of P60, deceased. There is an application for a Restriction Order in relation to parts of the statement that she has provided to the Inquiry. Subject to the Panel, I propose to deal with that application immediately itself, subject to restriction.

CHAIRPERSON: Yes. All right. As I've done in the past, in order to make the application effective, if I grant it, I will make an Restriction Order in relation to the application itself. That's a Restriction Order under Section 19 of the Act. There should be no reporting of this application until it's, in fact, been

1 resolved. Okay.

2
3 THE HEARING WENT INTO PRIVATE SESSION

4
5 THE HEARING RESUMED IN PUBLIC SESSION AT 10:19 A.M.

6
7 CHAIRPERSON: An application has been made for a
8 Restriction Order. I'm not going to go into the
9 details of it for obvious reasons. It relates to any
10 part of the following witness's evidence. I have 10:19
11 granted that Restriction Order, but so that those who
12 are interested, and the general public, if they want to
13 hear this material, they can hear as much as possible
14 from this witness, the Restriction Order will only be
15 effective part way through the witness's evidence, and, 10:19
16 Mr. McEvoy, you'll alert me when we're moving on to
17 that separate part. All of the evidence that follows
18 now until that Restriction Order becomes effective can
19 be reported. Obviously, the ciphers are still in place
20 and must be observed. 10:20

21
22 I meant to mention one other matter in relation to the
23 schedule; nothing to do with this witness, but my
24 apologies. Tomorrow on the schedule, we were going to
25 be hearing from P110's mother halfway through the day. 10:20
26 For good reason, unfortunately she's not able to attend
27 the Inquiry tomorrow. I have had an explanation for
28 that, which I have accepted, and her evidence will be
29 moved to 28th September, in the morning. We will, I

1 expect, be able to fill the time reasonably well with
2 the rest of the evidence we have tomorrow.
3
4 okay, Mr. McEvoy. Let's have the witness.
5 MR. McEVOY: Thank you, sir. P60's sister, please. 10:20
6 CHAIRPERSON: The formal order will be drawn up in due
7 course and then published.
8 MR. McEVOY: Thank you, sir. (Short pause).
9 THE WITNESS: Good morning.
10 CHAIRPERSON: Good morning. 10:21
11
12 P60'S SISTER, HAVING BEEN SWORN, WAS QUESTIONED BY
13 MR. McEVOY AS FOLLOWS:
14
15 CHAIRPERSON: Can I just thank you very much for coming 10:22
16 to assist the Inquiry. I'm sorry I haven't had time to
17 come through and meet you. However, I gather you only
18 got to the inquiry centre at about 9:50. Are you
19 settled now --
20 THE WITNESS: I am. 10:22
21 CHAIRPERSON: -- and ready to give evidence.
22
23 You have got your family liaison officer sitting there
24 next to you. Obviously he can assist but there's to
25 be, as I'm sure you understand, no discussion about 10:22
26 your evidence with him while you're giving it. I'm
27 going to hand you over to Mr. McEvoy.
28 THE WITNESS: Thank you.
29 1 Q. MR. McEVOY: Good morning. As you know, my name is

1 Mark McEvoy and I am one of the Inquiry's barristers.
2 Up to now you have been known as P60's sister. I think
3 we can see from your statement that you have used your
4 first name, which is P60's Sister, and you are content to be
5 known as P60's Sister?

10:23

6 A. Yes.

7 2 Q. Accompanying you today is your brother, and that's
8 P60's Brother?

9 A. Yes.

10 3 Q. We are going to be talking about your brother P60, and
11 we're not going to use any surnames. You're happy
12 enough with that?

10:23

13 A. Yes.

14 CHAIRPERSON: Can I just say, it's very unlikely to
15 happen in those circumstances, but if a name does get
16 mentioned which shouldn't, please don't fuss about it
17 or panic. We simply stop the feed and it is taken out
18 of the transcript. So, nothing will happen.

10:23

19 THE WITNESS: I'm happy enough for P60's surname to be
20 told.

10:23

21 4 Q. MR. McEVROY: I think to be preserve everybody's
22 dignity, we will just operate on the basis of first
23 names. That is how we've done things. If you're con
24 tent with that, we'll use your first name, P60's Sister.

10:23

26 What I'm going to do now is read out the statement that
27 is before the Inquiry, and hopefully you have it before
28 you there. It is dated 6th September 2023. If we look
29 at the back of it, it is 20 pages in length in terms of

1 the substance of the evidence. If I could ask you just
2 to turn to page 20. Maybe the liaison officer will
3 help you there; just page 20. I just want you to
4 confirm that it is your signature?

5 A. Yes.

10:24

6 5 Q. You can confirm also that you want to adopt then the
7 statement as the basis of your evidence to the Inquiry?

8 A. Yes.

9 6 Q. What I'm going to do now is read the statement into the
10 record. I'm going to be reading most of it in, and
11 then a little bit later we'll come back and read the
12 remainder. All right?

10:24

13
14 "I, P60's sister, make the following statement for the
15 purpose of the Muckamore Abbey Hospital Inquiry."

10:24

16
17 Then you indicate if you have any exhibits, you will
18 number them. You tell us:

19
20 "My connection with Muckamore is that I am the sister
21 of P60, deceased, a former patient of Muckamore. The
22 relevant time period that I can speak about is
23 13th November 2008 to January 2022. I am the only
24 sister of P60, who was a patient at Muckamore from
25 13th November 2008 until he died on 8th January 2022.
26 My brother P60's Brother is supporting me in the
27 statement-making process for the Inquiry. He has been
28 more closely involved with P60's circumstances since
29 he returned from Australia in 2014. P60's Brother hopes

10:25

10:25

1 this can be considered a joint statement by the
2 Inquiry.

3
4 There are four children in our family. We also have
5 another sibling named ^{P60's Brother}. My parents were P60 's 10:25
6 next of kin until my mother passed away on 11th January
7 2014, and my father then subsequently passed away on
8 28th August 2020.

9
10 **P60** was diagnosed with a learning disability when he 10:26
11 was six years old. He attended mainstream schools."

12
13 You identify them, a primary school in your hometown,
14 until age of seven, an elementary school and a school
15 in another town nearby. 10:26

16
17 "P60 then went to a special school until he was aged
18 11 and then to another special school from the age of
19 12 until he was 16.

20 10:26
21 P60 was diagnosed with chronic anxiety, depression,
22 post-traumatic stress disorder (PTSD) in December 1993
23 when he was 24 years old. He had sustained a head
24 injury when he was the victim of a sectarian assault in
25 [a town] in 1990 when he was 21 years old. P60 was 10:26
26 involved with the Community Mental Health Team since
27 1993. P60 's records stated he had "mild mental
28 retardation".
29

1 Since late 2007, P60 's mental health deteriorated and,
2 due to his symptoms, he required constant supervision
3 to reduce the risk of self-harm. P60 was verbal. He
4 was able to communicate with family, and his brothers
5 took him under their wing. They knew he had a
6 disability so they looked after him and helped him live
7 as much of a normal life as possible.

10:27

8
9 P60 lived in the family home with our mother and
10 father before his admission to Muckamore. He enjoyed a
11 quiet life on the farm looking after his animals,
12 cutting grass in the local community, and cutting turf.
13 P60 's pride and joy was his Massey Ferguson tractor.
14 P60 was heavily involved in the community delivery
15 turf. P60 would have been considered a gentle giant
16 in and around the area where we lived.

10:27

10:27

17
18 Throughout the years living at home, P60 never showed
19 any signs of violence. P60's Brother and I would
20 subscribe P60 as the most loving, caring, thoughtful
21 brother anyone could be blessed to have. P60 only saw
22 the good in people and he was well thought of in the
23 local community.

10:28

24
25 In or about 1990, when P60 was 21 years old, he
26 subjected to a serious sectarian attack and his mental
27 health deteriorated around that time, becoming anxious
28 and depressed. P60 's GP attributed his deterioration
29 to PTSD resulting FROM the sectarian attack. As a

10:28

1 result of that injury P60 , was admitted to Holywell
2 Hospital for short periods in 1993 and 1994 for
3 agitated depression and anxiety. I remember around
4 this time my parents saying that P60 complained of
5 head pain, chest tightness, and was having visions of 10:28
6 lying in bed or a coffin. I don't believe this was on
7 a daily basis but it was the start of a deterioration.

8
9 When P60 was 39 years old, he had a bad dose of 'flu
10 and, following, this, his mental health took a 10:28
11 downturn. I believe that the 'flu might have affected
12 P60 's mental medication. P60 's mental health
13 deteriorated and I believe this was like a relapse. He
14 was suffering with bad anxiety and was not in a good
15 place. 10:29

16
17 On P60 's 40th birthday, 22nd May 2008, he was
18 admitted as a voluntary patient to Tobernaven Upper,
19 an acute ward in Holywell Hospital, as there were no
20 beds in the psychiatric intensive care unit, or PICU, 10:29
21 at Muckamore. P60 was subsequently transferred to the
22 PICU on 4th July 2008. During this period, I recall a
23 nurse requesting a meeting to advise that Muckamore
24 would be more appropriate for P60 's needs. I did not
25 have any concerns about the transfer at this time and 10:29
26 believed that, as it was a medical decision, it was the
27 right decision for P60 .

28
29 P60 was admitted by way of a transfer to Cranfield

1 PICU at Muckamore on 13th November 2008. This was a
2 voluntary admission at this time. P60 's diagnosis on
3 entry was anxiety disorder, depression and borderline
4 IQ.

5
6 When P60 was admitted, my family was told he would be
7 assessed and treated. We were advised that P60 's
8 medication would be reviewed and he would be discharged
9 within about 12 weeks.

10
11 In addition to P60 's mental health issues, he also had
12 medical issues that are recorded in a letter dated
13 27th October 2008 sent from Holywell Hospital to
14 Muckamore, and include severe polydipsia and related
15 periods of hypernatraemia, as well as historically
16 aortic stenosis. I was never made aware of this at the
17 time and have learnt this information through medical
18 notes.

19
20 As a family, we all visited P60 on a regular basis.
21 My father would have visited every day and myself and
22 my mother would have visited four or five times a week.
23 Sometimes P60 would have had numerous visits per day.
24 Muckamore is not very far away from our home and
25 visiting was never an issue. Family visits were so
26 important to P60 . I remember him saying that other
27 patients would have passed remark on how frequently we
28 would attend and how much we must have loved him. I
29 attach Exhibit 1, photographs of P60 with family.

1
2 Visits were always held in either a visitor's room or
3 outside. We were never allowed on to the ward or into
4 P60 's bedroom. For a long time there were always
5 members of staff in the visitor room during visit and 10:31
6 it was difficult to get any privacy. Looking back, I
7 now believe the reason for the staff presence was to
8 monitor what P60 was telling us.

9
10 I have now been able to now compare these visits to 10:32
11 occasions when P60 was either sedated, had lost weight
12 or was bruised. I remember the staff would have been
13 being very friendly during visits and thought P60 must
14 have been their favourite, but, looking back, they were
15 just winning the family in and sitting in so P60 10:32
16 wouldn't tell us family anything.

17
18 P60 was only allowed to make telephone calls from the
19 nurses's station. He was not afforded any privacy
20 during these telephone call. P60 was not allowed a 10:32
21 mobile phone and they were told that the reason for
22 this was because of hospital policy. It was suggested
23 that the reason for this was that he might use a mobile
24 phone to self-harm, or that he will would take out the
25 SIM card and swallow low it as a form of self-harm. I 10:32
26 know my family doubted this as was there no previous
27 evidence or experience of this type of behaviour. P60
28 was very afraid of being overheard telling family about
29 being hurt or ill-treated. I used to ask for calls to

1 be referred to the visitor's room to allow for some
2 privacy, but afterwards P60 would ask that this was
3 not done again as he would be told off and told that he
4 was a bad boy. It was clear he was so afraid of the
5 consequences of reporting what was happening to him.

10:33

6
7 During his time at Muckamore, P60 required 2:1 care at
8 all times. I know that there would have been times
9 when he was not cared for by the required member of
10 staff. My family learned that this was due to staffing
11 shortages.

10:33

12 After approximately 12 to 18 months upon P60 's
13 admission, my family noticed a significant
14 deterioration in his presentation. Both P60 's mental
15 and physical health had deteriorated. My family felt
16 this was not due to P60 's diagnosis but rather it was
17 caused by something else. These issues were raised at
18 Muckamore but no one listened. It was at this point
19 that P60 was detained under the Mental Health (NI)
20 Order 1989.

10:34

21
22 I did not understand what detention meant, I was not
23 advised by any member of staff or social worker. I was
24 provided with no literature regarding detention and
25 what this meant regarding control of P60 's care.

10:34

26 Detention was significantly played down at the time and
27 I recall H40 referring to it as a paperwork exercise.

28
29 It was clear that P60 was losing a lot of weight and

1 he told me that there were times when he was only given
2 sandwiches for a meal. P60 would have enjoyed a large
3 dinner when he was at home; that was part of the family
4 home life. P60 's personal hygiene and cleanliness had
5 also become very poor. P60 required help with 10:34
6 cleanliness after toileting but it was clear that this
7 was not always being properly carried out.

8
9 At the beginning of P60 's admission to Muckamore, he
10 would have told family that some staff members were 10:34
11 being unkind to him. That was his language.
12 Unfortunately, we later learned that had included
13 actual abuse. As a result of these initial issues, my
14 family began to suspect something was wrong. In 2012
15 we wrote to an MLA, Trevor Clarke, raising our 10:35
16 concerns. P60 's notes and records showed that on 12th
17 March 2010, following a multidisciplinary team
18 discussion, P60 was declared medically fit for
19 discharge from hospital with effect from 12th March
20 2010. They correspondence indicated if he did not 10:35
21 leave hospital or if he was not formally discharged
22 within the next seven days, his name would be added to
23 the delayed discharge list from 19th March 2010.
24 However, although P60 was medically fit for discharge
25 from hospital on 12th March 2010, he remained a 10:35
26 detained patient and was not regarded to voluntary
27 status until 9th June 2010. On that date it was
28 indicated that he was no longer liable to be detained
29 in hospital under the Mental Health (NI) Order 1986.

1 It was indicated that he could remain in hospital as a
2 voluntary patient.

3
4 The notes and records indicate that P60 remained in
5 hospital after March 2010 because a suitable community 10:36
6 placement was not available.

7
8 From what I have seen, transfers within Muckamore
9 caused P60 further anxiety. On 11th October 2011,
10 following an episode, a further application for 10:36
11 assessment was sought and P60 became a detained
12 patient once more.

13
14 From 2011, P60 was detained under the Mental Health
15 Order. This detention was renewed annually. My family 10:36
16 were told by P60 's consultant psychiatrist, Dr. H40,
17 that P60 had to be detained because if he was
18 discharged from detention, he would 'come to our home
19 and murder us with a knife'. This was a real conflict
20 with our family experience of P60 and those in the 10:37
21 community who knew him, who regarded him as a gentle
22 person. This was really horrible as it seemed H40 was
23 trying to make my family believe that P60 was a
24 monster. The Muckamore staff were inside the heads of
25 my family. H40 also told my family that P60 was only 10:37
26 going to get worse and never going to get better. My
27 family believed him.

28
29 P60 's detention caused numerous issues. When P60 was

1 ill or had physical health issues, I would have asked
2 to bring him to Antrim Area Hospital for assessment. I
3 was told I was not allowed to remove P60 from
4 Muckamore as he was a detained patient. As no member
5 of my family was properly advised of the consequences 10:37
6 of detention, we did not know that we lost the ability
7 to take P60 to the hospital in this type of situation.
8 We had not appreciated that that was the significance
9 of his detention.

10
11 P60 's detention was reviewed annually before a Mental
12 Health Review Tribunal. My family did not fully
13 appreciate that we were also entitled to instruct a
14 solicitor and to attend on P60 's behalf. 10:38

15
16 For a period in or around 2012, P60 was allowed to
17 come home for weekend leave. Once P60 was allowed to
18 come home, he began putting on weight and he improved.
19 There had been a change in staff in the ward. However,
20 the weekend leaves were then stopped. We were told 10:38
21 that this was because P60 had become aggressive again.
22 The only noticeable change that we noticed at the time
23 was that this coincided with a change in P60 's
24 medication.

25
26 In or around 2012, I was told by staff that my father
27 was seen passing treats to P60 on CCTV. Muckamore did
28 not permit this as it meant some patients had things
29 and others did not. Muckamore made contact by 10:38

1 telephone to advise of this. We were advised all we
2 were allowed to bring P60 was an apple and a can of
3 drink. This was very hard as P60 looked forward to
4 his treats and we liked bringing them for him. We were
5 not aware of any cameras in Muckamore at this time.

10:39

6
7 As time went on, P60 seemed to lose interest in
8 everything. There were few activities in Muckamore for
9 P60 to do, except for playing pool. P60 came from
10 the country and before his admission to Muckamore, he
11 would have been outside, active and fully engaged.

10:39

12 I did have conversations with the staff on the ward
13 about getting P60 outside on the garden or the farm
14 because he had liked this in the past and it would give
15 him something to do. However, I was told that P60 did
16 not want to do this. It appeared to me that P60 was
17 lying in bed all day. P60 's main distraction seemed
18 to be smoking. P60 was a heavy smoker and would have
19 had a cigarette roughly every hour. We would have
20 provided a supply of cigarettes to him and he was
21 required 140 cigarettes a week. It was lucky that the
22 family lived nearby and we could all visit regularly to
23 attempt to encourage some activity. We would have
24 taken P60 out of the ward and, when we did, he was
25 very excited to get out. P60 would always be waiting
26 for the family to arrive.

10:39

10:40

10:40

27
28 Looking back to this period of time, I think P60 was
29 disinterested in activities because of his mental state

1 being poor from the abuse he suffered in Muckamore.

2
3 In or around January 2012, P60 telephoned me and told
4 me that he had been punched on the side of his head by
5 a staff member. P60 told me that he had made a 10:40
6 complaint about this within Muckamore, that he was
7 lying sleeping in his bed when the staff member entered
8 the room and punched him. The staff member, H251, a
9 safeguarding social worker rang me regarding this
10 incident and said I had misinterpreted it. After P60 10:40
11 made this complaint, the staff member took sick leave.
12 The staff member never returned to Muckamore and to me
13 this was a sign of guilt. I believe the staff member
14 retired with an early retirement package. The exact
15 words of P60 's consultant, H40, following this 10:41
16 incident was that P60 was diagnosed as having
17 behavioural problems. It seems to me at this point
18 that P60 was constantly sedated rather than managed
19 with the correct combination of medication. It seems
20 to result in P60 slurring his speech and foaming at 10:41
21 the mouth.

22
23 I complained directly to Muckamore about P60 's
24 treatment. I feel P60 was punished as a result of
25 complaints, as shortly after this particular complaint 10:41
26 we were told that P60 was going to be moved to
27 Birmingham to a different facility because he was too
28 violent to continue in Muckamore.

1 For a period of around seven to eight weeks after this
2 complaint, we were not permitted to visit P60 . We
3 were told that there was a risk of violence. During
4 this time, I believe that P60 was kept in seclusion
5 and only allowed out to eat. We rang Muckamore six to 10:42
6 seven times a day seeking an update but we would not
7 get to speak to P60 . We were told he was in seclusion
8 for his own safety and that for the family's safety, we
9 could not see him. This period of time really broke my
10 parents. 10:42

11
12 I suspect the treatment of P60 during this time was
13 due to the complaints which my family made about the
14 assaults on P60 , including assaults by H509. P60
15 said she was very bad to him. She would not open the 10:42
16 door to let him to the toilet, and would trip him, nip
17 him and taunt him. P60 also said that H54, a care
18 assistant, was bad to him. When we complained to the
19 ward manager, H515, an assistant manager H510, they
20 totally dismissed it. We also wrote to the service 10:42
21 manager, H77, with these concerns.

22
23 We subsequently received a letter which only provided
24 24 hours' notice to attend a multidisciplinary meeting.
25 We walked into the room and in attendance was 10:43
26 approximately 12 professionals, including social
27 workers and consultants. This was very intimidating/
28 we were told by H77 that Muckamore could do nothing
29 further for P60 and he needed specialised treatment

1 that he can only receive at a hospital in England. I
2 found H77 to be horrible and intimidating during this
3 meeting. Generally in my interactions with him, I
4 found him to be wholly unprofessional and quite
5 bullying in nature. In meetings he was constantly 10:43
6 talking over me and my parents when sharing my
7 perspective in my brother's care. He would be
8 dismissive, patronising, and never properly addressed
9 any concerns raised. We were provided with this option
10 alone and told to sign a Management Care Plan which 10:43
11 agreed with the move. We ultimately signed it although
12 we regretted this as we felt bullied and intimidated
13 into signing with no other option. After that meeting
14 we pleaded to see P60 . This was allowed and we were
15 taken to visitor's room. 10:44

16
17 The sight of P60 walking into the room on this day
18 will never leave me. I was shocked and appalled. His
19 body was skinny with a malnourished frame. He looked
20 like a dying man." 10:44

21 A. I'll never forget that day. Sorry.

22 7 Q. "It was heartbreaking for my family to see him so
23 neglected and sedated that he could hardly string two
24 words together.

25 10:44
26 I remember breaking down. I also remember my father
27 could not contain his emotions and walked out of
28 Muckamore crying. It was the first time I had ever
29 seen my father cry. We noticed bruising on P60 's body

1 but when we asked, we were told..."

2
3 CHAIRPERSON: Just pause for a second. (Short pause.)
4 Take a deep breath, take some water. Are you okay? We
5 can stop if you need us to. 10:45

6 THE WITNESS: Okay. Continue.

7 CHAIRPERSON: All right. Thank you.

8 MR. McEVOY: "We noticed bruising on P60 's body but
9 when we asked, we were told it was due to self-harming.

10 On this occasion P60 was begging us to help him. It 10:45
11 was heartbreaking to think of the fear P60 felt not
12 being able to see his family for weeks whilst being
13 abused, beaten and threatened with a transfer to
14 England. I believe one of the cruellest things to do
15 to P60 was to threaten to deprive him of contact with 10:45
16 his family. I believe the idea of being moved to
17 England without the possibility of frequent contact
18 with his mother and father, who were elderly parents
19 who had never been on a plane before, and his siblings,
20 would have been terrible for P60 . 10:46

21
22 After seeing P60 at this time, my parents' health
23 greatly deteriorated. My mother subsequently passed
24 away from cancer. I do believe that the stress
25 relating to P60 and his time in Muckamore contributed 10:46
26 to my mother's illness.

27
28 I am aware that P60 was again assaulted a second time
29 by a staff member, and again made a further complaint

1 which was referred to the Safeguarding Team. The
2 complaint was not addressed and we were told the reason
3 for this was because it had happened in a bedroom.
4

5 As a family, we made complaints to Muckamore about 10:46
6 P60 's care and treatment. My parents were made to
7 feel stupid for making complaints and made them feel
8 that they did not know as much as the professionals. I
9 really felt I could not turn to anyone, whether social
10 worker or manager, service manager RQIA; no one would 10:47
11 listen.

12 My family had numerous meetings with H40 who kept
13 quoting that P60 had behavioural problems. Dr. H50
14 just said the same when he took over as consultant. We
15 asked to bring P60 home but were told we had no rights 10:47
16 as he was still detained under the Mental Health Act.
17 I made numerous calls to the Head of Safeguarding at
18 Belfast Trust but no one would listen and it was always
19 the same outcome. They just said that P60 had severe
20 anxiety and behavioural problems, and the bruising was 10:47
21 self-harming.

22
23 I contacted my MLA, who arranged a meeting with H77,
24 service manager. This was the manager who then decided
25 that P60 's care needs could be in Muckamore instead of 10:48
26 England.
27

28 P60 's medical notes and records contained safeguarding
29 forms in relation to various incidents involving both

1 staff and patients. I was so concerned about P60 's
2 experience in Muckamore and the failure to obtain
3 proper responses to the queries raised that I
4 instructed Phoenix Law Solicitors to instigate judicial
5 review proceedings to challenge the decision of the 10:48
6 Department of Health as set out in its letter dated
7 19th April 2019, and support an application to permit a
8 public inquiry into Muckamore.

9
10 H40 was also the person to tell my family that P60 was 10:48
11 being sent for electro convulsive therapy. We had not
12 been asked for permission but when we asked, Muckamore
13 staff said he was a detained patient and we had no say
14 over his treatment. P60 went on to have numerous ECT
15 sessions. This got to the point where my family were 10:48
16 begging for it to stop because P60 did not want it and
17 he felt it was adding to his anxiety. H40 listed the
18 benefits of ECT when it was raised, and disregarded our
19 concerns. I remember my mother finding out that P60
20 had been for an ECT treatment when she phoned Muckamore 10:49
21 for a routine call, and then gasped in shock when this
22 was relayed.

23
24 I understand P60 's medication was changed often. We
25 were told that P60 was becoming immune to his 10:49
26 medication and that this was the reason for the change.
27 However, I noticed that after P60 had been on
28 medication for a while, he appeared to improve, and
29 then the medication would be changed and he would

1 deteriorate again. I would also notice that after
2 changes in medication, P60 had bruises. I was told
3 that the bruises were caused by self-harm. In relation
4 to P60 's change of medication, I did not ever receive
5 any phone calls or updates to advise of this. P60 10:49
6 used to say 'I started a new tablet tonight'. If my
7 family would have asked about medication, we would have
8 never been given the name. I don't believe P60 was
9 ever weaned off medication in Cranfield but this may
10 have happened in Six Mile. 10:50

11
12 There was a significant difference in P60 which I
13 attribute to medication. In earlier years, P60 was so
14 sedated he could not speak or walk. In later years, I
15 believe that staff withheld his medication 10:50
16 intentionally so that he would get uptight and then
17 they would mentally abuse him until he lashed out. It
18 was like a sport. There were times that staff recorded
19 that they had given P60 medication when he told me
20 that he had not received it. 10:50

21
22 I understand that on two separate occasions when P60
23 became unsettled during the night, rather than give him
24 the PRN medication which he was prescribed, the police
25 were called. As a result, P60 was tied to a 10:51
26 wheelchair and forcibly given an injection. I
27 understand this happened in Six Mile. P60 's
28 presentation and heightened anxiety on those occasions
29 was preceded with being taunted by Muckamore staff and

1 other patients regarding our father's dementia and
2 dying of Covid. This would have been a trigger for
3 P60 , which I understand everyone would be aware of. I
4 believe that when other patients taunted P60 with
5 personal information, they would have been told that 10:51
6 information by staff members. There is no other way
7 possible that other patients could have been aware, and
8 later P60 confirmed to me that the patients had told
9 him it was H512, a care assistant, had told them about
10 my father's illness. As a family we made a conscious 10:51
11 decision not to distress P60 with our father's medical
12 information surrounding our father's dementia, and this
13 family decision and trust was totally breached by the
14 staff.

15
16 I had been P60 's financial controller from around 2014
17 after my father was no longer able to continue. I was
18 asked countless times about the Trust taking on this
19 role. I felt that I was being pressured, and I
20 declined as I was concerned there would be insufficient 10:52
21 oversight of P60 's money, and in my view that was
22 necessary.

23
24 P60 had £40-£50 a week that he used for the Cosy
25 Corner Café. I discovered that during his time in 10:52
26 Muckamore, the staff were using P60 's money to pay for
27 taxis for trips as the hospital bus was out of
28 operation. After P60 's death, my family also found
29 out that staff had been using P60 's money to buy

1 takeaway food for themselves.

2
3 My family bought P60 presents, including a TV and DVDs
4 but they disappeared. Throughout the years he was in
5 Muckamore, my family spent hundreds of pounds on items

10:53

6 for him to try and make sure that he was as comfortable
7 as possible. This was in addition to the cash that we
8 regularly provided for him. The staff said that P60
9 smashed up his TV in a rage. P60 said that he did

10 not. P60 did not want us to say anything because he

10:53

11 thought he would get into trouble. The same thing
12 happened with four CD players. Each time one went

13 missing, staff advised that P60 had smashed them. My
14 father would say 'So long as P60 is safe, the items
15 can be replaced so say nothing to keep P60 safe'.

10:53

16 Electrical items, food, clothes, aftershave, money and
17 cigarettes all disappeared but we said nothing because
18 we knew that P60 would suffer the consequences.

19
20 My family also left money on the ward for P60 . P60
21 had £600 in the main office but when we asked for his
22 money, we were told that he did not have any money and

10:53

23 it must be a mistake. P60 always sought to be in
24 control of his money and had a sense of control after
25 it. Each Christmas, aunts would gift him substantial

10:54

26 sums and he would never allow us to take it home. We
27 understand that he was allowed £100 on the ward and at
28 least £600 was retained on the ward. Staff became very
29 abusive when my mother asked about this money. When

1 P60 was in Six Mile, staff discovered he had a Credit
2 Union and H13, Ward Manager, requested his book be left
3 on the ward. I refused this and received negative
4 responses from H13, and had a heated exchange
5 confirming I was his appointee and appropriately 10:54
6 dealing with finances. P60 always had money but there
7 was never really any clear accounting for the same.

8
9 During P60 's stay at Muckamore, there were patient
10 advocates available. However, they kept changing and 10:55
11 some were on long-term sick leave. P60 lost
12 confidence in the advocates.

13
14 I feel an advocate may have assisted when my father
15 died. P60 wanted to go to the grave but he was told 10:55
16 there was no available transport. P60 's money was
17 used to get him taxis. On one occasion, staff told
18 P60 they were bringing him to the grave but instead
19 they drove to a filling station nearby, which was only
20 a short distance away, a two-minute drive, and did not 10:55
21 allow him to visit the grave, which was torture. When
22 I spoke to the care assistant who transported P60 , she
23 told me that H260, Assistant Ward Manager, directed
24 them not to go to the grave and simply to go to the
25 shop and straight back. 10:55

26
27 I considered that there were long-term issues with the
28 management of P60 's physical health in Muckamore. I
29 had to push to get P60 referred for an MRI for pain in

1 his lower back. There is a family history of arthritis
2 and I knew that P60 needed bloods done to change his
3 inflammation markers. Nothing was done, and I made
4 repeated telephone calls until the MRI referral was
5 made. The results showed wear and tear on P60 's back. 10:56
6 Recommendation were made by physiotherapists that P60
7 should play basketball but this was not carried out.
8 Another MRI scan was taken and staff said it showed
9 deterioration from the previous MRI. However, the
10 doctor said it showed scoliosis. Our family had no 10:56
11 help from the ward staff.

12 At one stage I complained about a mattress being
13 inadequate because it was so uncomfortable that P60
14 was sitting in a dayroom chair at night. I offered to
15 buy P60 a mattress. A nurse told me it would not be 10:56
16 approved by health and safety, and another staff member
17 asked who I thought I was for making this offer. One
18 doctor said to me 'Do you think you're a doctor, do you
19 think you know better?'

20
21 I recall one Boxing Day when I was visiting P60 , I
22 checked his legs and they were badly swollen. I rang
23 the ward and they said they had not noticed. No body
24 charts had been done. I asked for P60 to be seen by
25 the out-of-hours doctor and it turned out to be fluid 10:57
26 from sitting in a chair at night. As a result, P60
27 was placed on a fluid tablet.

28
29 On another occasion when P60's Brother and I were

1 visiting P60 , we saw that his back was badly bruised.
2 This was on 19th February 2019. P60 had been
3 complaining about back pain in the days before this but
4 we thought it was just the usual lower back pain. P60
5 was reluctant again to say anything about what had 10:57
6 happened. On Sunday 24th February 2019, we were
7 visiting again and the bruising was still obvious. We
8 checked with the nurse in charge, H226, who looked at
9 his back. We asked for a doctor to examine it. We
10 felt that he should go to A&E. A doctor from Muckamore 10:58
11 looked at his back and said there was nothing to be
12 concerned about. I insisted that he needed to be
13 referred to hospital but the answer was 'You're not a
14 doctor so it's not your call.'

15
16 My family continued to seek referral for the back pain.
17 At this stage the police also became involved as staff
18 refused to bring P60 to A&E. Eventually, P60 went to
19 Antrim Area Hospital but only after the intervention of
20 police. The doctor there said the injury would have 10:58
21 happened a few days prior and drained 250ml of fluid
22 from the injury. The doctor in Antrim Area Hospital
23 said P60 was very lucky because there was a high
24 chance of it getting infected and then it could have
25 turned to sepsis. The doctor also said that the wound 10:58
26 would need to be checked and dressed to avoid infection
27 but when we phoned the next day, no staff had checked
28 it. We queried why we were not told about the injury.
29 We were initially told it happened on 17th February

1 2019 but then this was changed to 14th February 2019.
2 We were also told that P60 punched a staff member,
3 then tripped, but this could be disputed by the CCTV.
4 Even after this incident, my family had to chase the
5 changing of the dressing to avoid infection. We had a 10:59
6 meeting afterwards at Muckamore regarding this
7 incident. We asked whether P60 's safety could be
8 guaranteed but the representative from Muckamore in
9 response 'Nothing in life is guaranteed, you could get
10 caught up in a car accident on the way home.' 10:59

11
12 I strongly believe that this incident was covered up.

13
14 Every year, P60 would get a chest infection. It
15 seemed this was not treated and would I have to insist 10:59
16 that the nurses give P60 an antibiotic.

17
18 P60 also got rashes all over his body on so many
19 occasions but staff did not advise our family or refer
20 P60 to the doctor. P60 would say that his skin was 11:00
21 sore and itchy and I would then have to ask for a
22 referral to the doctor. I was told it was eczema and
23 then a different condition, yet no medicated ointments
24 were sought to treat P60 's skin unless I asked for
25 this. P60 also suffered from constipation and I had 11:00
26 to asked on numerous occasions for Laxido.

27
28 I would say that any physical issues with P60 were
29 raised almost in reverse. I felt like I was the nurse

1 because I was raising all these issues to the medics.
2 I am not a medical professional. I was never contacted
3 by any Muckamore staff during P60 's time in Cranfield
4 about a physical health issue. I recall when I would
5 have chased the hospital to check up on referrals or 11:00
6 medical appointments, there was no sense of urge
7 urgency or priority. I was often advised that they
8 forget due to being under a lot of pressure.

9
10 My family are also aware that in the notes and records, 11:01
11 there is correspondence from 352 Healthcare to P60 at
12 Cranfield dated 19th January 2012, and notifying P60
13 that a referral to 352 had been received and asking
14 that an appointment be arranged, and a further letter
15 dated 20th February 2012 removing P60 from the 11:01
16 appointment waiting list because an appointment had not
17 been arranged.

18
19 I asked on numerous occasions for medical notes, as
20 well as a summary of P60 's medication and copies of 11:01
21 minutes of meetings regarding P60 's assessment. These
22 things did not happen. I had no medical experience but
23 I was always the one to alert P60 regarding P60 's
24 physical health. When I asked why his physical health
25 was not met both medically and psychologically, staff 11:01
26 said P60 played up and there was nothing wrong with
27 him.

28
29 Seclusion was a major issue. I understand it was used

1 extensively. I believe P60 was regularly placed in
2 seclusion or voluntary confinement. P60 's notes and
3 records contained numerous references to this.
4 Extracts from a single week in October 2021 are
5 provided with this statement by way of example, showing 11:02
6 that the use of seclusion/voluntary confinement
7 occurred every day during this one-week period. The
8 records contain similar records throughout P60 's time
9 in Muckamore.

10
11 P60 described seclusion as a 'dark dungeon', there was 11:02
12 nothing in the room, only a single mattress on the
13 floor, and he would be made to stay in there for hours.
14 Initially P60 did not tell me any of this. I believe
15 he was too afraid. P60 was not allowed to go to the 11:02
16 bathroom. He got no food and he lost weight. P60 was
17 obsessed with getting a cigarette and Diet Coke, and
18 staff were not providing these. I understand there
19 could be CCTV of footage of P60 being in seclusion for
20 hours without staff coming to him. 11:03

21
22 In later years, P60 would have said that he wanted to
23 be locked in his bedroom but he never told me or any of
24 his family that he wanted to go to seclusion. He hated
25 seclusion. I have subsequently been told by police 11:03
26 P60 spent most of six months in seclusion. However, I
27 have not been told how often this was happening. I
28 understand there's access to a toilet and P60 told me
29 he was not given medication, not allowed for smoke

1 breaks, and not given any food. Staff, H13 was the
2 main one who laughed when I enquired about P60 's
3 concerns. I recall him saying 'You're a very
4 protective sister, you need to get a life.' This was
5 just another example of the culture in Muckamore. 11:03

6
7 One particular incident I recall at Six Mile during my
8 visit, P60 was getting anxious as it was near his
9 smoke break. He was rubbing his hands but showing no
10 signs of aggression. H511 sitting, a care assistant, 11:04
11 sitting in on the visit left the room and returned very
12 soon after with H13 Ward Manager and H355 nurse.
13 Without warning or notice, they physically restrained
14 P60 and trailed him out of the room. P60 was
15 shouting 'Leave me alone', and I ran out after them. 11:04
16 They forcibly pinned P60 to the wall and I was told to
17 immediately leave for my safety as P60 was going to
18 become violent. I was shouting to leave him alone and
19 that this was an assault. I was then forcibly removed
20 by H13 from the Hospital. I called that afternoon and 11:04
21 spoke with H13, who apologised for the earlier incident
22 but it was for my own safety, and ultimately they had
23 to place P60 in seclusion due to his alleged
24 aggression that I simply did not see. I called a
25 second time that day around 6:00 p.m. and spoke with 11:04
26 P60 . He was very reluctant to talk and I kept probing
27 him. He confirmed he was in seclusion, received no
28 evening meal or drink, and assured me he was not
29 aggressive or violent at the time. The treatment was

1 wholly degrading.

2
3 H355 was P60 's designated nurse. P60 would have told
4 me on numerous occasions that he would do bad things
5 and was not a nice person. I raised this with the Ward 11:05
6 Manager H13. He would laugh it off and say something
7 similar around me just being a protective little
8 sister, and that P60 tells lies. Shortly after, I
9 noticed bruising on P60 's arms and when I again
10 questioned this, I was told it was down to 11:05
11 self-harming. This simply did not make sense so I
12 contacted Safeguarding and without explanation or
13 warning, H355 was no longer P60 's designated nurse but
14 did remain on the ward.

15
16 I am concerned about information in P60 's notes and
17 records, particularly in the seclusion plan in 2017,
18 which seems to suggest that staff would be denying
19 P60 's drinks and use of the toilet.

20
21 It also states within P60 's note that he would request
22 seclusion and that being locked in would make him feel
23 safe. I questioned why P60 had to be locked in to
24 feel safe and secure within Muckamore ."

25
26 I'll pick it up at paragraph 71:

27
28 "In 2015 P60 was moved to the Six Mile Ward. After
29 this P60 was transferred to Cranfield PICU on six

1 occasions for overnights. I know my family were upset
2 about P60 being placed among forensic patients, but
3 when this was raised, staff were so rude and said it
4 was nothing to do with them. P60 was detained and we
5 were told he would be going to Six Mile because there
6 was an available bed. I understand in July 2015 CCTV
7 was installed on the Six Mile Ward and in the Cranfield
8 wards."

11:06

9
10 On the top of page 13 then, paragraph 78:

11:07

11
12 "My cousin, contacted Muckamore after H512 was
13 transferred to another ward and asked why he had not
14 been suspended. Eventually we learned that H512 had
15 been suspended.

11:07

16
17 I understand from what P60 told me that abuse also
18 occurred in bedrooms and bathrooms. I believe these
19 were not investigated because those areas were not
20 covered by CCTV.

11:07

21
22 After we found out about the abuse P60 had suffered,
23 we asked for him to be provided with therapy to help
24 him cope. We were told this was not being provided to
25 him because P60 did not want it. We were convinced
26 that was not correct.

11:07

27
28 Another patient would go into P60 's room and use
29 sectarian language and beat him up in his room. This

1 patient would call P60 a 'Fenian bastard'. This was
2 the language that was used when P60 was beaten up at
3 the age of 21 years. The patient said he knew this
4 because H512 had told him. This language was a trigger
5 for P60. Staff were not involved in the sectarian 11:08
6 abuse but they did not stop it. Another patient had to
7 be moved because of sectarian abuse. This patient
8 harassed P60 for months and months, saying things like
9 'H512 told me your Daddy is dying'. H512 would tell
10 other patients things about P60's family and they 11:08
11 would use this to taunt P60. Two days after our
12 father died, P60 was beaten up in his room by a
13 violent patient.

14
15 I brought up the use of sectarian language by that 11:08
16 other patient with H260, Assistant Ward Manager, and
17 the effect on his PTSD from the attack. She advised
18 she asked someone to have a word. At the time H260
19 laughed when I raised it and says 'He calls me a Fenian
20 bastard all the time. Don't take it so personally, 11:08
21 P60's sister ' ,

22
23 On one occasion the Safeguarding Team called me and
24 told me that P60's door had been forcibly kicked open
25 at 3:00 a.m. by a staff member. Later, I was told that 11:09
26 the footage had been misinterpreted and the
27 Safeguarding Team backtracked. Referring to this
28 incident, P60 said that the staff member had punched
29 him in the side of the head and called him a bastard

1 during this incident.

2
3 At this point I wanted to speak to the senior
4 management of RQIA. They said they would investigate
5 it and would arrange a visit to the ward but they only 11:09
6 arrange announced visits. I called RQIA numerous times
7 and requested copies of minutes but I got nowhere. I
8 reported that P60 was being assaulted, that he was not
9 getting therapy, that there were issues with
10 resettlement. I was always told that it was being 11:09
11 investigated but I never saw the product of any
12 investigation. The RQIA eventually stopped taking my
13 calls. They said they wanted to arrange a visit and
14 made recommendations but they advised they were always
15 happy with the ward. They advised that there was never 11:09
16 anything to say something needed changed.

17
18 Eventually I just stopped ringing the RQIA. I thought
19 they were the ultimate overseer, and I did not know who
20 to go to if I was dissatisfied with them. I simply 11:10
21 lost total confidence in them taking any meaningful
22 action. I did not know about the PCC until later
23 years. I felt the RQIA were just as intimidating as
24 management in Muckamore. On the occasion when P60
25 said he was punched by staff when he was sleeping, 11:10
26 Safeguarding said it would have to be investigated. I
27 remember being totally dissatisfied with their approach
28 and I recall P60 saying 'Who would believe me'?
29

1 Covid-19 was very stressful and an anxious time for
2 P60 as the news was never off in the ward, reporting
3 details about deaths. P60 was worried about his
4 father in a care home. When I spoke to P60 , he was
5 crying and so afraid we were all going to die. I 11:10
6 believe that staff told P60 he was going to die, which
7 can only be described as inhumane.

8
9 I understand now that staff tested positive for
10 Covid-19 but this was not relayed to my family. P60 11:11
11 had no support during Covid-19. He was mentally and
12 physically abused and was not allowed to see his
13 family. I intended and asked could I see P60 at the
14 window and speak to him. I was told to go away. P60
15 was standing crying on the other side. Our father had 11:11
16 passed away in August and this was at Christmas time.
17 I think it is interesting that a different charge nurse
18 allowed me to visit and stand outside with P60 , but
19 when I arrived at Muckamore when H260 was on duty, I
20 was not allowed to stand outside with P60 . She made 11:11
21 him stand at the front window instead.

22
23 In the summer of 2018, at a meeting with consultant
24 Dr. H50, representatives of the Trust advised that P60
25 would be resettled into the community. They advised me 11:11
26 that a property was identified and earmarked for him.
27 P60 was taken to the property on a number of occasions
28 with me, and the Family Liaison Officer attended a
29 number of meetings with the Northern Trust throughout

1 2018.

2
3 From in or about February 2019, meetings about P60 's
4 resettlement started to be cancelled. For example, a
5 number of meetings were arranged with H183, Assistant 11:12
6 Director for Learning Disability, but were cancelled at
7 the last minute, and no updates were provided. Upon
8 reflection, when my brother and I were invited to
9 resettlement meetings, we felt that our expectations
10 and views for P60 to live in suitable alternative 11:12
11 accommodation outside Muckamore were never genuinely
12 listened to or given any weight.

13
14 Following this, in or around March and April 2019
15 Northern Trust contacted P60 and advised that they 11:12
16 were continuing to look at resettlement. However, the
17 property was no longer suitable as P60 was assessed as
18 requiring a bungalow and there were no nearby
19 properties which were suitable for him. This was not
20 previously advised and, in fact, P60 had attended that 11:13
21 property on occasions as part of settling in.

22
23 The clinical staff in the Belfast Trust at Muckamore
24 assessed P60 as fit for discharge on 26th June 2019.
25 The Northern Trust Resettlement Team claimed to have 11:13
26 been conducting baseline assessments to provide them
27 with overview of P60 's needs, which produced the view
28 that P60 had a range of complex needs. This whole
29 process seemed to drag and neither my family nor P60

1 could see an end to it when he would be discharged.
2 There was discussion of alternative placements in
3 Coleraine and Carrickfergus, however this was never
4 agreed or taken further with the understanding that
5 P60 needed to be close to family. I understand the 11:13
6 baseline assessments were subsequently misplaced or
7 lost.

8
9 Once again, we were let down by both the Northern and
10 Belfast Trusts. We had no option but to issue judicial 11:14
11 review proceedings to compel P60 's speedy discharge to
12 a suitable placement in the community. Unfortunately,
13 this came to an end with P60 's death.

14
15 In P60 's last few years, he wore dentures. He did not 11:14
16 like wearing the bottom set of the dentures as it
17 affected his eating. As part of P60 's anxiety, he ate
18 his food very quickly. I noticed over two or three
19 years that P60 's swallow was deteriorating and he was
20 having choking episodes. This was known about in 11:14
21 Muckamore, and he was also assessed by a speech and
22 language therapist. Again, I had to request this
23 assessment.

24
25 At one stage I was told that P60 would require a soft 11:14
26 food diet. However, after the assessment it was
27 advised that P60 could eat normal food because he was
28 supervised when he ate. P60 previously really enjoyed
29 it when we would bring him treats such as Macdonald's

1 or pizza. The Assistant Ward Manager H260 told me that
2 we were not allowed bring him such treats again. The
3 family as a whole felt H260 disliked us because of her
4 unprofessional attitude and her behaviour towards us.
5 We were not sure if forbidding those treats was in
6 P60 's interest or just done to punish P60 .

11:15

8 In May 2019, P60 attempted suicide at Muckamore by way
9 of self-harming his wrist with the glass from his
10 watch. P60 never self-harmed before he went into
11 Muckamore. This only started in Muckamore. I do not
12 believe that all the bruising which P60 sustained came
13 from self-harm. P60 consequently told me that H512,
14 care assistant, had said he was going to England if he
15 reported abuse, and threatened that he would never see
16 his family again. He also taunted him every day by
17 saying things like 'your Da is dying. Your two
18 brothers think you're nothing but a no-good bastard.
19 You're going to die on your own. You're evil and
20 you're useless'.

11:15

11:15

11:16

21
22 P60 had a choking episode on 19th February 2017. He
23 choked on a piece of chocolate. This led to a referral
24 to speech and language therapy and a swallowing care
25 plan was then provided for P60 . It was completed by a
26 speech and language therapist, H514, and dated 27th
27 February 2017. It contains a list of the handwritten
28 heading "Risky Foods" with a tick a category, round or
29 long-shaped foods, sausages, grapes, sweets, hard

11:16

1 chunks like pieces of apple. There is a handwritten
2 note which states 'Need can cut up'.

3
4 On 7th January, I was contacted by a male nurse to ask
5 if P60 had ever had Chicken Pox as there were cases on 11:16
6 the ward and they were trying to avoid an outbreak. I
7 asked my aunt about this and rang back to say that P60
8 had chicken pox when he was younger.

9
10 My brother P60's Brother rang the ward at seven o'clock 11:17
11 that evening to ask if P60 was okay. The nurse who
12 answered him told him that P60 was fine and that a
13 doctor had been called and that there was an ambulance
14 there as back-up. I remember saying to P60's Brother
15 that I felt something was not right as it would be very 11:17
16 unusual to call an ambulance during a pandemic. At
17 this stage we were told that P60 had choked at
18 lunchtime and by 6:00 p.m. his breathing had
19 deteriorated. I could hear P60 in the background
20 calling 'Is that my sister'. P60 wanted me to ask the 11:17
21 doctor if he could go out for a cigarette. I was told
22 that they wanted to take P60 to Antrim Area Hospital
23 because his breathing was poor and he had a possible
24 chest infection. I was told they were waiting on an
25 ambulance. I rang back an hour later around 8:00 p.m. 11:17
26 and the ambulance had still not come. It was 8:45 p.m.
27 when I called again and I was informed that P60 had
28 left in the ambulance for Antrim Area Hospital.

1 I was unable to attend Antrim Area Hospital because of
2 Covid-19 restrictions. At approximately 11:30 p.m.
3 P60 was still not back and I was told that they were
4 waiting on an X-ray. I asked to be called when he came
5 back from the X-ray. Someone from Antrim Area Hospital 11:18
6 then called me at 12:30 a.m. on 8th January 2022 and
7 told me that I needed to come to the Hospital because
8 P60 was very unwell.

9
10 When I attended the hospital, the doctor, who I believe 11:18
11 was an out-of-hours doctor, asked if I knew what was
12 happening. At this stage neither myself nor
13 P60's Brother really understood what was going on. The
14 doctor told us that a piece of fruit had lodged in
15 P60 's lung and blocked it and that he had suffered a 11:18
16 heart attack and that he had passed away. P60 died
17 that night at Antrim Area Hospital.

18
19 I could not understand what I had just been told. I
20 kept saying 'No, you must be mistaken, P60 could not 11:19
21 be dead.' We were taken to see P60 lying on a bed.
22 P60 was gone and, after all the abuse he suffered, he
23 was now dead. It felt like the world fell to pieces
24 that night. We have no words for the shock, and to
25 this day we still cannot believe P60 is not here. I 11:19
26 visit P60 's grave every day and it is still like that
27 a bad dream that I have not woken from. P60 went to
28 Muckamore for assessment and medication but was
29 detained and abused for years. On 7th January 2022

1 when P60 choked, if my family had been contacted and
2 spoken to P60 , he might still be here but it's now too
3 late. My loving, caring big brother is no longer here
4 and that void will never be filled.

5
6 I do not understand why it has taken so long to bring
7 P60 from Muckamore to Antrim Area Hospital,
8 particularly as it is not far away from Muckamore.
9 P60 could have been brought in a car if an ambulance
10 was not available. P60 was on his own when he died,
11 and the fact that P60 never had his family with him
12 will never ever leave me.

13
14 I would ask the Inquiry to consider the notes and
15 records in relation to P60 's death and the preceding
16 period. The notes indicate that P60 choked on his
17 apple around lunchtime. The notes from Antrim Area
18 Hospital will also be relevant. The swallowing
19 assessment on 20th February 2017 also specifically
20 identifies hard chunks like pieces of apple as a risky
21 food for P60 .

22
23 After P60 died, we brought P60 home. On 9th January
24 2022 my telephone rang at about 3:00 p.m. and it was a
25 withheld number. It was a nursing manager from
26 Muckamore who wanted to speak to me. My cousin
27 answered and said I was not in good form and that there
28 were people in the house. That was the only phone call
29 I received from Muckamore after P60 died. No one from

1 Muckamore came to the wake or attended the funeral. No
2 flowers were sent. I was in the height of grief and
3 shock. Muckamore had been P60 's permanent home, yet
4 no one came to offer their condolences. Myself,
5 P60's Brother, nor any other member of my family has
6 heard from any of the staff at Muckamore since.

11:21

7
8 SW2, the Family Liaison Officer, rang the following
9 week to see how I was. A part-time doctor who worked
10 two days per week at Muckamore sent an email to offer
11 condolences to my family. H220, the Ward Manager of
12 Six Mile, did not call. SW2 lodged an official
13 complaint about H230 with management as he had
14 contacted him and said that I needed to come and get
15 P60 's belongings from the hospital. SW2 called and
16 answered for permission to collect P60 's things on my
17 behalf.

11:21

11:21

18
19 When SW2 went to collect P60 's belongings, all of his
20 things had been thrown into black bin bags. SW2 made
21 an official complaint to the Belfast Trust about this
22 incident as well. He said it was an absolute disgrace.
23 P60 's belongings were provided in hazardous waste bags
24 and a grey box which had a Serious Adverse Incident
25 leaflet thrown at the top of P60 's personal items. I
26 attach at Exhibit 2 photographs of the belongings.
27 This was another devastating episode for P60's Brother
28 and me. Our brother P60 was not treated with respect
29 when he was alive by those working in Muckamore, and it

11:22

11:22

1 is shameful and despicable that his belongings were
2 then treated in this manner after he passed.

3
4 When we got P60 's belongings back, lots of things were
5 missing. For example his electronics and his 11:22
6 aftershave were not returned. I sent an email to SW2
7 with a list of items that were not returned, including
8 his electronics, expensive aftershave, and a
9 substantial sum of monies that should have been in the
10 main office. 11:23

11
12 P60 had complained of a tight chest for years but this
13 was never investigated at Muckamore.

14
15 I have really suffered mentally because of P60 's abuse 11:23
16 and death. Even to this day when I close my eyes at
17 night, all I can see was the assaults on P60 . I am
18 traumatised by the abuse of my brother and I feel that
19 I am a tortured soul. P60's Brother and my life has been
20 totally devastated due to the treatment of what my dear 11:23
21 brother was exposed to and as a result of this sudden
22 death. We remain deeply affected by the abuse, neglect
23 and exploitation my brother suffered whilst in the care
24 of Muckamore.

25 11:23
26 Since the Muckamore investigation, I have suffered
27 terribly during living in the town which is the local
28 area for many Muckamore staff. I recall a very
29 traumatic incident recently when I was visiting P60 's

1 grave. H54's father was standing at the entrance to
2 the graveyard and waved at me and laughed. The father,
3 H209, was P60's behavioural nurse while P60 was in
4 Cranfield. I feel like I have not been allowed to
5 grief. This trauma is still ongoing and I have
6 considered moving to another town. I cannot put into
7 words the effect this has had on me. This has made me
8 feel that I was somehow the abuser and not a victim.
9 When I go out, I constantly look over my shoulder and
10 feel intimidated and harassed living in my own
11 hometown. I increasingly feel like a prisoner in my
12 own home, and had to install CCTV and security lights
13 at my own expense, to which the Belfast Trust had
14 approved and then backtracked...

11:24

11:24

15
16 The life P60 ended up living in Muckamore was one he
17 should never have had to live. He was robbed of his
18 life. When he had lived at home, he had a normal life.
19 He was a worker.

11:24

20
21 I want to ensure that another patient will not suffer
22 what P60 suffered for all those years. I feel that no
23 one should have to keep up the kind of vigilance that I
24 will felt was necessary to maintain for P60 to keep a
25 loved one safe. Even then, I could not fully protect
26 him from harm. I also feel that families should not
27 have to resort to legal proceedings to protect the
28 interest of their loved ones, and protect themselves.
29 During P60's time in Muckamore I felt it was organised

11:25

1 that patient families were not given an opportunity to
2 interact with each other. I believe this was in fear
3 that issues would be discussed.

4
5 In my view, although senior management kept being 11:25
6 replaced over the years, they were all the same; they
7 told lies, they were intimidating, the made false
8 promises and they were bullies. They were defensive
9 about their staff. 'P60 plays you up', one of them
10 said to me one day. 11:25

11
12 As time has passed, we have heard nothing of substance
13 from Belfast Trust relating to our brother's death, and
14 still remain to be updated in respect of the adverse
15 incident reporting. It is now six years on and we 11:26
16 still do not have any acknowledgement or answers to the
17 damage and devastation Muckamore has caused to our
18 lives. It has been extremely traumatic trying to come
19 to terms with the hundreds of incidents of abuse
20 perpetrated against P60 which I believe contributed to 11:26
21 his untimely death. No one can ever justify or should
22 cover up the inhumane and degrading treatment our
23 brother was subjected to. We as a family believe that
24 our beloved brother P60 abjectly failed in his aspects
25 of care with Muckamore, Belfast Trust and the Northern 11:26
26 Trust."

27
28 CHAIRPERSON: I think there should be a "was abjectly
29 failed" in that. All right. Okay.

1
2 The next part of the process is that Mr. McEvoy will
3 ask you questions. He's not going to go through the
4 whole statement again but he'll ask you questions on
5 topics which he thinks may be of particular interest to 11:27
6 the Panel. You have been sitting there now for about
7 an hour and ten minutes, and I imagine that even
8 listening to that account, which I know you know well,
9 must have been difficult for you. So, what we'll do is
10 we'll take a relatively short break, about 15 minutes. 11:27
11 The Inquiry staff will look after you.

12
13 I should have welcomed your brother P60's Brother as
14 well. I'm sorry. Thank you very much for coming in.
15 Then we'll start again at about quarter to. We'll get 11:27
16 through Mr. McEvoy's questions based upon this part of
17 your statement. Then we will go into the restricted
18 session, which I think you have been told about, so
19 that Mr. McEvoy can deal with parts of your statement
20 which have been bound by the because they refer to 11:27
21 potential criminal proceedings. All right? Does that
22 all make sense?

23 THE WITNESS: Yes, it makes sense. Thank you.

24 CHAIRPERSON: Thank you very much. We'll take a
25 15-minute break and you'll be looked after by staff. 11:27
26 Thank you.

27
28 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
29

1 CHAIRPERSON: Thank you very much.

2
3 THE WITNESS WAS QUESTIONED BY MR. MCEVOY AS FOLLOWS:

4
5 8 Q. MR. McEVOY: Thank you Chair, thank you, Panel. 11:52

6 P60's Sister, I have just a small number of questions arising
7 from the comprehensive and detailed statement that you
8 have given to the Inquiry. Hopefully, SW2 will be able
9 to assist you with the paragraphs and the pages I'm
10 going to take you to. The first one relates to what 11:53
11 refers is at paragraph 15 on page 3, please, if you
12 would turn that up.

13
14 P60's Sister, in this paragraph, just to briefly sort of
15 summarise what's here, is a discussion about P60 11:53
16 making phone calls home from Muckamore. Here you tell
17 us about P60 only being allowed to make phone calls
18 from the nurse's station, and the impression you have
19 that he was not afforded any privacy during those
20 telephone calls. Can you tell us a little bit more 11:53
21 about that, in particular how was it that you had the
22 impression that you convey in your statement that he
23 didn't have privacy?

24 A. I could hear staff in the background. We would have
25 made, as a family, two to three phone calls a day but 11:54
26 he always got his evening phone call at half-seven and
27 then he had another one between half-nine and 10:00.
28 You could hear staff speaking very loudly in the
29 background. They were speaking loudly.

1
2 And then on different occasions I had said about
3 getting the phone calls referred to the visitor's room,
4 and P60 had said, ', I'll get into trouble, I'm a bad
5 boy'. And he would have got very hesitant and quite 11:54
6 nervous and I would have said 'What's wrong, P60 ',
7 and he said 'No, no, I'll get into trouble, I have to
8 sit here with the staff'. But the staff were always in
9 the office, I could hear them speaking and I could hear
10 them talking even about other patients on the ward. 11:55

11 9 Q. So the Inquiry is clear then, what you're describing is
12 more than just the background bustle of the ward, the
13 comings and goings; it's people very close to the
14 phone?

15 A. No. I could hear the staff speaking loudly in the 11:55
16 background.

17 10 Q. Okay. Okay. Then in the very next paragraph then, at
18 16, you explained to us that during his time at
19 Muckamore, P60 required two-to-one care at all times.
20 You go on and say there would have been times where he 11:55
21 was not cared for by the required number of staff; the
22 family learnt this was due to staffing shortages.

23

24 Really two points arise there. How often do you think
25 it was less than the two-to-one ratio that P60 was 11:55
26 supposed to have; how frequently would that have been?

27 A. Over the years or in late --

28 11 Q. You can be as specific as you can. I mean, if you have
29 a general impression over the period from 2008 until

1 his death, first of all?

2 A. Initially we weren't told that P60 needed two-to-one
3 care when he was in Cranfield, but P60 was so badly
4 sedated, his mobility, his whole posture, everything,
5 he was falling over. When I had met, you know, with 11:56
6 the ward manager, they said that they were going to
7 provide two-to-one care more because of his mobility.

8 12 Q. Okay.

9 A. And they had said that this was happening. But when I
10 spoke to P60, he had said there was never any staff. 11:56
11 Like, I'll give you one example. P60 was in a
12 two-to-one due to patients that had beat him up due to
13 the sectarian language that was going on in Six Mile,
14 and I was told that a staff member would be outside his
15 bedroom at all times. But on different occasions, 11:56
16 P60's bedroom door was kicked open by members of staff
17 and also by patients who beat him up in his bedroom.
18 So, it wasn't happening. I feel that this was put in
19 like a care plan to, you know, cross things through and
20 make it look like it was happening, but it definitely 11:57
21 wasn't.

22 13 Q. Okay.

23 A. And even on a two-to-one, like P60 was getting out to
24 go to the shop in the evening, there was no staff with
25 him when he was going to the shop. 11:57

26 14 Q. Okay. Do you know roughly -- obviously he was in there
27 from 2008, as we know. Do you know how far along his
28 journey in Muckamore that he was ascribed the
29 two-to-one?

1 A. Later years. It was in the last four years before he
2 passed away.

3 15 Q. Okay. You described somebody just a moment ago being
4 outside his bedroom. Did you say at all times; did I
5 pick you up correctly? 11:57

6 A. Yeah. They had said that even there was -- like, every
7 15 minutes someone would go into his bedroom to check
8 on him, to check that he was okay, and that even when
9 he was in his bedroom, because he'd felt probably as
10 well safe in his bedroom. So, when he went to his 11:57
11 bedroom, they said, right, well, we'll let him stay in
12 his bedroom but the staff member will be outside.

13 16 Q. Yeah.

14 A. But...

15 17 Q. Just on that point in fact, because a little bit later 11:58
16 in the statement you talk about -- you distinguish for
17 us P60 liking to be locked in his bedroom, and you
18 distinguish that against seclusion?

19 A. Yeah.

20 18 Q. That desire to be in his bedroom and the being locked 11:58
21 in, I mean how did he come to be want to be locked in?
22 What do you think prompted that?

23 A. Well, I know he was in seclusion which he described as
24 the horrific dark dungeon that he was forcefully put
25 into every day for a long period of time. And then 11:58
26 when it all became public about this dark dungeon, it
27 was done away with. So, then we were told that they
28 were using the bedrooms as seclusion. But when I spoke
29 to P60 , when he, in later years, came out about the

1 abuse, he said that he felt safe when he was in his
2 bedroom, and that's why he asked for the bedroom door
3 to be locked. But at that time, you know, as I said to
4 P60 , the door can still be opened on the outside. He
5 said, 'I feel safe if I'm in my bedroom and I know my 11:59
6 door's locked, that nobody can come into my bedroom and
7 beat me up'. That was P60 's words.

8 19 Q. Again, how far along P60 's journey in Muckamore do you
9 think that would have been, that he expressed it to
10 you? 11:59

11 A. That was in later years because initially when P60 was
12 in Cranfield, P60 didn't tell us about the abuse. It
13 was only in the last two years prior to his death that
14 he starting speaking out about it. He said that some
15 members of staff that abused him were removed from the 11:59
16 ward. But initially, no.

17 20 Q. Okay.

18 A. Initially he wasn't locked in his bedroom. He spent a
19 good part of his time in seclusion in Cranfield.

20 21 Q. Okay. Going back then to what was on page 3 then in 11:59
21 terms of the deterioration. Paragraph 17, you describe
22 this as beginning around 12 to 18 months after P60 's
23 admission. So, would that have been then maybe
24 sometime in 2009/2010?

25 A. Yes. It was around 12 to 18 months after he was 12:00
26 admitted.

27 22 Q. When you describe it being raised, who in particular --
28 it was someone in the family who raised it with
29 Muckamore?

1 A. My mum.

2 23 Q. Okay. Do you know at level your mum would have raised
3 it?

4 A. She reported it to the ward manager at that time. I
5 think she went through the assistant manager, ward 12:00
6 manager. And then at that time, you know, P60 had
7 said about the member of staff that was very bad to
8 him, that was his words. And then at that time, she
9 felt she was getting nowhere and we had wrote a letter
10 to [H77], the service manager at that time. 12:00

11 24 Q. Okay. I think that man, that gentleman has a cipher,
12 so we'll just pause there for a second.

13 CHAIRPERSON: You're absolutely right. If we just cut
14 the feed.

15 MR. McEVOY: You identified an individual. 12:01

16 CHAIRPERSON: Thank you.

17 25 Q. MR. McEVOY: Overleaf on page 4 then, you describe,
18 just at paragraph 19 at the top of the page, P60 's
19 weight loss to begin with. Can you give us an idea
20 when you first started to notice weight loss? 12:01

21 A. Again, it was like 18 to 24 months when he was
22 admitted. Because P60 , P60 was a strapping lad, you
23 know, he loved his food, but we noticed weight loss.

24 26 Q. A farmer's son, as you say?

25 A. Yeah. And he really, really lost weight. My mum at 12:02
26 the time, my mum and dad had raised it. I remember
27 they were told, oh P60 suffers from depression, this
28 is normal to lose weight but we knew it wasn't normal.
29 Even P60 's whole appearance, he had gone into himself.

1 27 Q. Mm-hmm.
2 A. He wasn't speaking, you know. It was just like he had
3 gone off his food. We were taking him special treats
4 up which he loved, and he didn't want them. Didn't
5 want to eat. 12:02
6 28 Q. In terms of his personal care that you also describe in
7 that same paragraph, needing some help with his
8 toileting and cleaning himself and so on, was that
9 something that he had required prior to his admission
10 into Muckamore? 12:03
11 A. No, no.
12 29 Q. And how was that need identified?
13 A. Well, before P60 went into Muckamore, he had washed,
14 bathed every day. He had taken great pride in his
15 appearance and his dress sense. That all disappeared 12:03
16 after he was admitted to Muckamore, after, like, so
17 many months, to the point when I want to visit, or mum
18 or dad went to visit, you could actually smell -- you
19 know, the odour was on his clothes, and you noticed
20 that his clothes were stained. You just said, 'You 12:03
21 know, P60 '... He lost all total pride within himself,
22 even down to his toilet needs.
23 30 Q. So, as you say, that lack of sort of self care or pride
24 in self-care, that's something that, from what you're
25 telling us, you're attributing to a kind of a mental 12:03
26 health issue as opposed to an aspect of P60 's need
27 arising from a learning disability?
28 A. No, I'm putting it towards the abuse, because P60 had
29 a mental health learning disability before he went into

1 Muckamore. Looking back now, this is the abuse and the
2 lack of care that he suffered, and this is what
3 contributed to P60 's just appearance, his, you know,
4 weight loss. Everything.

5 31 Q. Mm-hmm. In terms of the weight loss and the personal 12:04
6 care issues, were those raised with Muckamore staff?
7 A. Numerous, numerous times.

8 32 Q. Okay. Were you given any sort of positive response?
9 A. No. For example, one comment from a member of staff
10 was 'We can't force him to eat. We can't force him to 12:04
11 clean his bum'. That was language that was used from
12 the medical staff.

13 33 Q. That's from the medical staff?
14 A. Yeah.

15 34 Q. At paragraph 24 - 23 really I suppose, if I can take 12:05
16 you to 23 on that same page - you describe an episode
17 in October 2011. Are you able to describe what that
18 episode was?
19 A. Number?

20 35 Q. It's paragraph 23. So, I'll just read the sentence out 12:05
21 for you:
22
23 "From what I have seen, transfers within Muckamore
24 caused P60 further anxiety and on 11th October 2011,
25 following an episode, a further application for 12:05
26 assessment was sought."
27
28 Do you see it there?
29 A. What had happened was, that was P60 being transferred

1 to another ward. Now, P60 was in Cranfield when he
2 was admitted, and then at this time they had come to
3 say that P60 had been transferred to Six Mile. Now,
4 at that time I didn't know that Six Mile was a forensic
5 ward. So, P60 was transferred there and we had asked 12:06
6 why. Why would P60 be in with forensic patients?
7 Like, that is not a suitable ward for him. So, we were
8 told that there was no beds so he would have to go.
9 Well, actually the member of staff at that time
10 forcefully just said 'We don't have a say in it, P60 's 12:06
11 being transferred to another ward'. And we had said
12 right, okay, if there's no beds, can this be done slow
13 and at P60 's pace, you know, take him over, let him
14 get to know the staff, let him get to know the
15 patients, because anyone with a learning disability or, 12:06
16 you know, things have to be done slowly. They can't
17 just make a change overnight, they have to take time to
18 adjust. And I know my brother P60 more than anyone
19 and I know that P60 could never cope with change, even
20 when he was younger. You had to, like, break P60 12:07
21 gradually into things. But that's what that refers to,
22 was the transfer over to Six Mile.

23 36 Q. Okay.

24 A. Looking back now, you can see that they seemed to want
25 failure, seemed to want, like, maybe aggression to 12:07
26 sedate P60 , you know, to add to his PTSD and his
27 severe anxiety.

28 37 Q. Just on the topic of Six Mile, the Inquiry has heard
29 that there were two sides to Six Mile?

1 A. Yeah.

2 38 Q. A treatment side and an assessment side? Do you know
3 which side P60 's bed was on when he was moved there?

4 A. P60 was transferred from side to side. When P60 went
5 in he was on the assessment side and, you know, he was 12:07
6 transferred over. But unfortunately when he was Six
7 Mile, he kept getting transferred from unit to unit
8 because of the bullying from other patients by P60 . I
9 put in the statement about the sectarian language so
10 that they had to keep moving him. 12:08

11 39 Q. Can you tell us roughly how frequently those swaps
12 would have happened?

13 A. It could have happened -- like, there was one period,
14 it was quite a long period, it was maybe like six
15 months and he was moved over. And then another time he 12:08
16 got staying for a longer period and the patients were
17 moved and P60 got staying. Then they tried to
18 encourage P60 to go over to the treatment side to a
19 pod but he just said no. He just lost all interest.
20 He just said no, let me stay on this side and lock my 12:08
21 bedroom door and then hopefully I'll -- well, he didn't
22 say "hopefully". He said, well, I might be safe.

23 40 Q. You described Six Mile as being a ward for forensic
24 patients. Were you given any explanation as to why it
25 was thought that Six Mile was -- any medical 12:08
26 explanation or clinical explanation, I suppose, as to
27 why Six Mile was thought to be a better place for P60 ?

28 A. They just said there was no beds in the hospital side,
29 and that was the only available bed. Because P60 also

1 was a detained patient, again it was put back 'this
2 isn't your decision'.
3 41 Q. If I can take you to 31 on page 5. The very last
4 sentence in 31 is where you tell us a little bit, as
5 you do throughout your statement, about P60 's 12:09
6 experience of sedation. The very last sentence says:
7
8 "It seemed to me at this point P60 was constantly
9 sedated rather than managed with the correct
10 combination of medication. It seemed to result in P60 12:09
11 slurring his speech and foaming at the mouth."
12
13 Can you recall how long again into P60 's Muckamore
14 journey he would have begun to be sedated?
15 A. It was a short period after P60 was admitted, because 12:10
16 initially we were told it was for a 12-week assessment,
17 but after a matter of months P60 looked like a stroke
18 patient and that's what he looked like. A young man,
19 stooped over, slurred speech, foaming at the mouth.
20 42 Q. The type of medication and its potential side-effects, 12:10
21 were those things discussed with you by clinical staff?
22 A. No, no. Looking back, he was on antipsychotic drugs.
23 I had asked numerous times for a list of his
24 medication, and the only time that I was given that was
25 when I thought P60 was getting released, was to apply 12:10
26 for his PIP. When I looked at the drugs and the amount
27 of medication that he was on, there's no words how he
28 was drugged. He was drugged. And, like, so sedated,
29 he could hardly -- there were times he could hardly

1 string a conversation. He could hardly string two
2 words together.

3 43 Q. I suppose on the topic, elsewhere in the statement you
4 talk about the use of PRN medication or P60 having one
5 prescribed to him. Was the use of the PRN and its 12:11
6 potential side-effects discussed with you?

7 A. No.

8 44 Q. Or with your mum and dad?

9 A. No. My mum, she had asked, you know, a lot of
10 questions in the early part of P60 's time in Muckamore 12:11
11 but there was never -- no answers. I'm being honest,
12 any time we sat down to speak - as I say, the early
13 days it was more my mum and dad - you just felt that
14 you were being intimidated, you were being bullied and
15 the attitude was how dare you ask, how dare you ask 12:12
16 questions.

17 45 Q. You knew then that there was a PRN which had been
18 prescribed to him. How did you find out about that?

19 A. One of the nurses, the assistant manager at that time
20 in Cranfield, had said that if P60 -P60 gets very 12:12
21 violent so we have to give him PRN to settle him.

22 46 Q. Okay. So it was almost by the way that you were told
23 this, rather than --

24 A. Yeah.

25 47 Q. -- it being formally conveyed to you in a formal 12:12
26 setting?

27 A. It went from that in Cranfield, to Six Mile that it
28 went to the complete opposite, but they repelled
29 medication off P60 because P60 said I haven't -- they

1 don't give me my tablets. He'd been banging on the
2 door, you know, he was fixated for his medication then
3 because that's all that was given to him over the
4 years. So it went from one end to the other end.

5 48 Q. You very graphically and movingly described, on page 6 12:12
6 paragraphs 35 and 36, going to the multidisciplinary
7 meeting and you describe P60 being very malnourished.
8 On reading that passage, you get the impression that
9 this malnourishment took place over quite a brief
10 period of time? 12:13

11 A. Yeah.

12 49 Q. Can you tell us a little bit more about that?

13 A. I'll never forget seeing P60 that day until the day I
14 die, because at that time it all started with P60
15 saying a staff member was very bad to him. 12:13

16 50 Q. Yeah.

17 A. And my mum had went down there, up the ranks and
18 reported it. They had said, you know, about not being
19 able to meet P60 's care needs and all, and all of a
20 sudden we weren't allowed to see P60 . 12:14

21 51 Q. Yeah.

22 A. And it was, like, for I would say roughly seven to
23 eight weeks. We rang, I don't know how many times. We
24 rang every day. 'You can't speak to P60 on the phone,
25 he's really aggressive, he's really violent, you can't 12:14
26 see him'. That broke my father's house. My father
27 went every day religiously, sometimes twice a day, to
28 see P60 . And he still drove up to that hospital to
29 make P60 's treats in, to be told you can't see P60 ,

1 he's violent. And Daddy said that's not my son, my son
2 is not violent, and they said we can't let you in for
3 your own safety. And that continued for eight weeks.
4 And we rang and rang and rang, no, you can't see him,
5 you can't see him.

12:14

6 52 Q. It was after that period then when you finally did get
7 to see him?

8 A. We got called to this meeting. And we begged, we
9 pleaded, to see P60 .

10 53 Q. Yes.

12:15

11 A. And after the meeting they said we'll go and get P60 .

12 P60 walked up the corridor. I'd say he'd probably
13 lost about three stone in weight. He was foaming at
14 the mouth. There was a staff member on each side of

15 him walking him up towards us, and he got on his knees
16 and he begged us to help him. He said 'please Daddy,
17 please help me. Please, please help me'. My father -
18 it was first time I'd seen my father cry - and he
19 hugged and hugged P60 , and he turned around and said

12:15

20 'P60's Sister, will you sort this' and he went out of the
21 Hospital. The cruelty and the abuse that was inflicted
22 on my brother, it's just -- I'll never forget that day.
23 Obviously we don't have proof, we don't have proof but
24 we know now that P60 was locked up. And P60 said
25 that he was locked up, he was put in seclusion, he
26 wasn't fed, he wasn't allowed out to go to the toilet,
27 he wasn't given smoke breaks. You wouldn't treat an
28 animal like that. And this for whatever length of
29 time.

12:15

12:16

1
2 And then we got the local MLA involved and, all of a
3 sudden, P60 's needs could be met at Muckamore. It was
4 more bullying tactics that happened. My brother
5 suffered. He suffered so much. And the hurt and the 12:16
6 pain that these people put my parents through.

7 54 Q. You've come to the Inquiry to tell us all about it.

8
9 Before you came to the Inquiry, and indeed I know you
10 were involved, as you say in your statement, you spoke 12:16
11 to some other bodies and entities. You described the
12 RQIA, and you described how you got on with them.
13 Thinking back, how were you made aware of the existence
14 of the RQIA? who told you they were there to speak to?

15 A. I knew myself about the RQIA. I knew, you know, what 12:17
16 they were involved in and what I thought they done, but
17 I was very wrong. I reached out to them so many times
18 and I got no help, no assistance, I was constantly
19 knocked back. And P60 was let down also by the RQIA.

20 55 Q. You also then, I think, mentioned the PCC as well. In 12:17
21 terms of the role of the PCC, what did you first become
22 aware of it?

23 A. I seen a leaflet one time in the hospital in reception.
24 That's when I became aware.

25 56 Q. Can you remember whenabouts roughly that would have 12:18
26 been? I know we're talking about quite a period.

27 A. I'm going back to P60 's time in Six Mile. I went in
28 one day and I was sitting in the reception area to see
29 him, and I happened just to be at the reception area

1 and I looked at the leaflet.

2 57 Q. okay.

3 A. No one ever told me, nobody ever advised me when I was

4 at this hospital visiting P60 . It was just because of

5 a leaflet that was sitting. 12:18

6 58 Q. And nobody ever told you -- or were you ever told that

7 there was a HSC complaints process?

8 A. No. No. I didn't even know even for P60 about the

9 advocate. I wasn't ever told about anything like that.

10 Like, I know this is nothing to do what with what 12:18

11 you're asking but --

12 59 Q. No, it is. It's about other people that could have

13 helped, and anything you can tell us about that is very

14 important.

15 A. Even families, we were kept apart. We weren't even 12:19

16 allowed to speak to each other. Like, for example, if

17 you went into the reception area, quickly you were

18 shoved into a visitor's room. So, you know, it's not

19 as if you had support and could speak to another family

20 and say, you know, who are you dealing with, is there 12:19

21 anybody that could help you.

22 60 Q. I was just about to ask you about that because you

23 describe that very, very strikingly in your statement,

24 if I might say, and you had the impression that you

25 were kept about. Can you tell us more about that and 12:19

26 how you formed that impression?

27 A. Well, one example is my father and me had gone up to

28 Cranfield to visit P60 , and we had gone into the

29 reception area and there was another obviously mother

1 and father sitting. And we went in and I remember as
2 well the receptionist jumped up, and said oh P60's Father,
3 P60's Sister, I'm going to take you down to the visitor's
4 room. Daddy was a countryman and loved to speak and
5 have a chat, and he said 'Oh no, we're all right 12:19
6 sitting here, we'll be okay'. And next minute, she
7 must have pressed a buzzer because there was a member
8 of staff. They were so nice to us when we came to
9 visit, 'Oh P60's Father, P60's Sister, come on up here, I'll make
10 you a cup of tea', blah-blah. That happened on 12:20
11 numerous occasions. We were always kept apart.
12 MR. McEVOY: Okay. Those are my questions at this
13 point. It may be that the Panel have questions for you
14 arising from.

15 CHAIRPERSON: Dr. Maxwell. 12:20

16
17 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS
18 FOLLOWS:
19

20 61 Q. DR. MAXWELL: That you for sharing his story. You talk 12:20
21 a bit about him wearing dentures in the last few years?

22 A. Yes.

23 62 Q. Can you tell us what his dental health was like before
24 he went into Muckamore. Did he have any problems with
25 his teeth? 12:20

26 A. Yes. P60 had suffered over the years. He had
27 different abscesses. I'm trying to think. I can't
28 remember exactly the age but he was probably in his
29 late 20s, he was admitted to the Royal Victoria and he

1 had all his teeth removed, you know, so he had wore
2 dentures. He had worn dentures for a number of years
3 before he went into Muckamore.

4 63 Q. Right. And was that full dentures or just partial?
5 A. Full dentures. 12:21

6 64 Q. But before he went to Muckamore, he was able to eat
7 properly?
8 A. Oh, yeah.

9 65 Q. So, the dentures weren't stopping him eating?
10 A. We used to keep P60 going that he was the only person 12:21
11 we knew who could eat an apple without dentures, so
12 that shows you how his appetite was. He was a great
13 eater; he loved his food.

14 66 Q. Okay. That was going to be my second question. Would
15 the fact that the dentures didn't fit properly have 12:21
16 stopped him eating?
17 A. No.

18 67 Q. But you are saying he would chew with his gums?
19 A. He would have chewed with his gums. I used to by him
20 Wine Gums, and he'd said 'You don't need to buy me Wine 12:21
21 Gums, I'm not a baby, I can eat toffees'. So no, he
22 was quite able to eat without dentures.

23 68 Q. Do you think he got any help with keeping his mouth
24 clean when he was in hospital?
25 A. Well, I used to leave him up his denture tablets in his 12:22
26 wee case and I used to say to him every -- you know,
27 make sure you steep them every night with your tablet
28 to keep them fresh, and rinse them out the next
29 morning. Because he was -- even before he went to

1 Muckamore, P60 's cleanliness was outstanding. So I
2 had that routine in my head, make sure you, you know,
3 steep your dentures at night.

4 69 Q. When you say he, for whatever reason, lost his sort of
5 sense of pride in his appearance, did you get the 12:22
6 impression that the staff were cleaning his dentures?

7 A. No, no, because there's times I went up to visit him
8 and I used to get him to take out his teeth. And there
9 was times even I went into the visitor's bathroom to
10 wash them out. 12:22

11 DR. MAXWELL: Okay. Thank you.

12 CHAIRPERSON: Thank you. Professor Murphy?

13 PROF. MURPHY: I wanted to ask you a bit about the
14 early days of his admission, if I may. You say in
15 paragraph 22 that he was diagnosed with PTSD -- well, 12:23
16 anxiety disorder, depression. Did he have treatment
17 for anxiety and depression apart from medication? Did
18 he have any psychology assistance, for example?

19 A. Before, in the earlier days?

20 70 Q. Well, in the earlier days at Muckamore. 12:23

21 A. Sorry, can you just ask the question again?

22 71 Q. So, when he was first admitted to Muckamore --

23 A. Mm-hmm.

24 72 Q. -- and the diagnosis was anxiety and depression --

25 A. Yeah. 12:23

26 73 Q. -- did he have any psychology help?

27 A. No, no. Because that was one of the things we had
28 asked on numerous occasions about, you know,
29 psychiatrists and they had said that it was offered.

1 Now, this was in later -- in early days, no, but in
2 later years when P60 was in Six Mile, they had said it
3 was offered but P60 had declined. But when I had
4 spoke to P60, what P60 said was nobody came to see,
5 nobody came to speak to me. And he would have turned 12:24
6 around and said 'They're telling you lies again,
7 P60's Sister '. But it wasn't offered in the early days.

8 74 Q. The kind of medication you would normally use for
9 anxiety and depression wouldn't be antipsychotics. So,
10 did he start off on different medication, do you think, 12:24
11 than what he went on to?

12 A. His medication was changed so often. When we queried
13 about, you know, the change of medication, every time
14 it was, like, 'because of P60 's condition he gets
15 immune to the medication so we have to keep changing 12:24
16 it'.

17
18 I feel as well, looking back, when P60 started to do
19 good and progress and put on weight, all of a sudden
20 his medication was changed. It was like this patient's 12:25
21 doing good here, you know, let's change his medication.
22 If anybody knows of a change of medication, you know,
23 there is a drop in behaviour. P60 wasn't weaned off a
24 lot of his medication, some of it was just stopped
25 instantly and restarted on a new medication. 12:25

26 75 Q. Why do you think that staff would change his medication
27 if he was doing well?

28 A. Exactly, he was doing well. It was like P60 's doing
29 well. Looking back now, he's doing so well here, we'll

1 change it, and, you know, put him through hell again,
2 because that's what happened to him over the years.
3 And it was seen by the bruising on the body, the
4 bruising and -- you know, like even looking at P60 's
5 hands, he had them bit and bit. You know, it was like 12:26
6 the pressure, the pain. And I used to say to him, you
7 know, about the pain in his back and all, and he just,
8 like, 'It's in here, it's in here' (indicating). As we
9 all know, psychological damage, the pain, the mental
10 torture outweighs physical any day of the week. So I 12:26
11 think that's what P60 was trying to tell me in his
12 way.
13 PROF. MURPHY: Okay, thank you.
14 CHAIRPERSON: I have a few questions. Would you just
15 give me a second. 12:26
16 THE WITNESS: Okay. (Short pause.)
17 76 Q. CHAIRPERSON: I just wanted to clear something up. I
18 just want to, first of all, understand something which
19 I suppose was quite basic. P60 was obviously verbal.
20 A. Yes. 12:27
21 77 Q. Could speak to you. And had capacity, so most of the
22 time he knew what was going on around him?
23 A. Yes.
24 78 Q. You clearly asked about the medication that he was on,
25 and you told us that it was changed often. Were you 12:27
26 ever given -- were you ever told 'well, we can't
27 discuss the drug regime he's on because he has capacity
28 and that's, you know, a private matter'.
29

1 was that ever said to you or were they happy to discuss
2 the medication with you? How did it work?

3 A. well, different times -- like, earlier admission, you
4 know, mum had dealt with the affairs. When she had
5 asked about medication, it was all played down and, you 12:27
6 know, my mum felt like, how dare you question me, like,
7 I'm the doctor. You know, I remember my mum saying to
8 me, you know, like years ago, like, doctors were seen
9 as God, you don't question them. But she felt
10 intimidated by how can you question me in this? 12:28
11

12 And then in later years, for example with the
13 consultant, when I had asked different questions, he
14 had said to me, 'I can't answer that because P60 has
15 full capacity'. That's what was said to me. 12:28
16

17 But then on another occasion, for example resettlement,
18 he tried to say that P60 didn't have full capacity and
19 that he was a detained patient. So, capacity suited
20 when it suited the consultants. 12:28

21 79 Q. Were you ever able to get a list -- you said his
22 medication was changed a lot. How did you know it was
23 being changed?

24 A. P60 was told. There was a ward round on a Tuesday,
25 and when I spoke to P60 in the evening time, he would 12:28
26 have said, whatever consultant at that time, 'I'm
27 starting on a new tablet, I'm starting on a new
28 tablet'.

29 80 Q. So this was all coming through P60, really?

1 A. Yeah. And also when I had checked in on the ward, I
2 had spoke mainly with night staff, you know, because
3 P60 had numerous phone calls at night; they would have
4 confirmed a change of medication.

5 81 Q. Yes, okay. 12:29

6 A. But they also did say we can't confirm any details; if
7 you have details about medication, if you want to make
8 a phone call, an appointment with the consultant.

9 82 Q. Right. Can I just ask you about something different.
10 In paragraph 48 of your statement, you're talking about 12:29
11 P60 's money?

12 A. Mm-hmm.

13 83 Q. You say:

14

15 "After P60 's death, my family also found out the staff 12:29
16 had been using P60 's money to buy takeaway food for
17 themselves."

18

19 I don't want to know any names, please, but how did you
20 find that out? What was the source of information? 12:29

21 A. That I know that?

22 84 Q. Yes.

23 A. Well, obviously it's through the investigation, but
24 P60 had also said to me prior to his passing that he
25 had said that there was, like, Chinese being delivered 12:30
26 on a Saturday night, and I said did you get a Chinese,
27 and he'd said that the staff take it, and he said like
28 I know they're using my money because they said to me
29 on different times, this is like our -- like, not

penance but for what we've had to put up this week with you, so we're using some of your money to treat ourselves to a Chinese.

85 Q. Sorry to have to ask this but you'll understand why,
did you trust what P60 -- were you able to trust what
P60 said to you? 12:30

A. Very. Because see at the start when P60 had said to me about members of staff were bad to him, I didn't believe him. You know why I didn't believe him - and this will never leave me, the guilt that I didn't believe my brother - because I thought no one could be this bad, no one could do this.

But now I look back, I'm the one that was in the wrong that I didn't believe him, because now I know every word he was telling me was nothing about the truth.

86 Q. Paragraph 57 of your statement, again I just want to
get an understanding of how this happened. You had
mentioned before about p60 's back pain. You said:

"My family continued to seek a referral for the back pain."

Then you said:

"At this stage the police became involved."

A. Yeah.

87 Q. How did that happen?

1 A. When we had gone to visit P60 on the Sunday, he was
2 shaking in the chair, he was reluctant to say about his
3 back pain, and then we had asked for the out-of-hours
4 doctor. So, she came in, and when I seen P60 's back,
5 it was so swollen and it was like a bruise, an old 12:31
6 bruise.

7 88 Q. Where?

8 A. It was here, at the bottom of the spine.

9 89 Q. You're pointing to the bottom, right above the nape of
10 the back? 12:32

11 A. Yes. It was just pus and fluid. Anyway, the
12 out-of-hours doctor, she had came to look at it and she
13 just measured with a ruler and she just said 'He'll be
14 okay'. And I said 'P60 's in pain and he also needs a
15 referral; he needs to be taken to A&E because there's a 12:32
16 lot of pus and fluid there and', that's when she said
17 to me that day, you know like, 'I think know best, I'm
18 the doctor'.
19

20 Yet again, rang that evening, P60 was complaining 12:32
21 terribly with the pain. A few phone calls that night,
22 and then the next morning I had rang, so I had, to ask
23 for an update and asked for the doctor on the ward to
24 see him. And then my brother^{P60's Brother} he had also rang
25 and there was a doctor at that time - after, I think it 12:32
26 was maybe two or three phone calls - there was a doctor
27 seeing him and he had confirmed that P60 was okay.
28 But when I spoke to P60 on the phone, he was saying he
29 was in so much pain. So, when I spoke to the doctor, I

1 said P60 needs referred to A&E, and he was the one who
2 says 'I'm the doctor, why do you think you know better
3 than me'.
4 90 Q. Right.
5 A. And that was when my brother ^{P60's Brother} rang the police to 12:33
6 explain the situation.
7 91 Q. I see, okay. So, it was the family who involved the
8 police?
9 A. Yeah. Within 15 or 20 minutes there was an ambulance
10 up at Muckamore to take P60 to A&E. 12:33
11 92 Q. Okay. Finally this from me, you'll be glad to know.
12 If you go to paragraph 63, you're talking about
13 seclusion, and you say that he was regularly placed in
14 seclusion or voluntary confinement?
15 A. Yeah. 12:33
16 93 Q. "P60 's notes and records contain numerous references.
17 Extracts from a single week are provided with this
18 statement by way of example." We haven't actually got
19 that. Has that been provided to your solicitors or to
20 the Inquiry? Do you know where that is? 12:34
21 A. That's with my solicitor.
22 CHAIRPERSON: Right. We are going to ask, please, for
23 that. All right.
24
25 That's all that I've got to ask you for the moment. Do 12:34
26 we now need to go to restricted session? We're not
27 going to rise. I don't think there's any need to. The
28 Restriction Order that I made earlier will now take
29 effect. So, can I ask anyone who has not signed a

1 confidentiality agreement or isn't a CP, please to
2 leave the room. The feed to Room B is now, please, to
3 be cut, and we're now in restricted session.

4 MR. McEVOY: Thank you, Chair.

5 CHAIRPERSON: I'm sorry, the transcript obviously will 12:34
6 need to be separated.

7
8 THE HEARING WENT INTO PRIVATE SESSION

9
10 THE INQUIRY CONTINUED IN PUBLIC SESSION AFTER LUNCH AS 13:25
11 FOLLOWS:

12
13 CHAIRPERSON: Thank you. So, we've got some reading to
14 do this afternoon. Obviously those whose statements
15 are being read are being entitled to zoom in, as it 14:10
16 were, and watch, so we may have to have a slight pause
17 in between each to make sure the right people can watch
18 their own statements being read. So where do we start?

19 MR. McEVOY: I'm going to start with the statement
20 P63's sister, dated 1st April 2023. Panel, so that you 14:11
21 know and as has been the case so far, of course, those
22 watching, the statement-makers watching are aware, of
23 course, that the Core Participants, and of course the
24 Inquiry itself have the totality of the statement and
25 indeed an opportunity to absorb them. 14:11

26
27 what I propose to do is to read in as much of the
28 statement as is possible. There may be some parts that
29 I summarise. If that's an agreeable way to proceed,

1 that's what's proposed.

2 CHAIRPERSON: That is. Obviously we'll leave it to you
3 to summarise those parts you think can properly be
4 summarised, but everybody should understand the Panel
5 will have read all of the statement. 14:12

6 MR. McEVOY: Yes. Thank you, Chair.

7 CHAIRPERSON: Thank you.

8 MR. McEVOY: I'll begin then with P63's sister telling
9 us that she has made the statement for the purpose of
10 the Inquiry; that she will exhibit her documents in the 14:12
11 normal way; confirming that her connection with
12 Muckamore is that she is a relative of a patient. The
13 relevant time period she can speak about is between
14 1992 and 2018.

15 14:12
16 Section 3, I will take it up there to begin with:

17
18 "My brother, P63, was admitted to Muckamore on 17th
19 December 1992, according to records from the North and
20 West Belfast Health and Social Services Trust held by 14:12
21 my father. He remained a resident of Muckamore until
22 2018. P63 was born on 19th February 1975 and died on
23 19th February 2021 aged 47 years old.

24
25 I was told by my mother, who has provided a statement 14:12
26 to the Inquiry, that P63 was born deaf, tongue-tied,
27 with cerebral palsy."

28
29 I'm not proposing to read the following paragraphs,

1 that is the remainder of 3, 4, 5 and 6. I'm going to
2 take it up at paragraph 7. The reason why I am going
3 to do that --

4 CHAIRPERSON: In short, she challenges whether that
5 diagnosis was correct or not.

14:13

6 MR. McEVOY: That is right. Then there is an
7 explanation of some family history which isn't relevant
8 to the Inquiry's Terms of Reference.

9 CHAIRPERSON: Which, again, the Panel is aware of. All
10 right.

14:13

11 MR. McEVOY: "I would like to take this opportunity",
12 she tells us at paragraph 7, "to tell the Inquiry about
13 my brother from a sister who loves him dearly and who
14 misses him every day.

15
16 After I became aware that P63's experience was part of
17 the Inquiry, I found some documents that my father had
18 kept which record P63's time in Muckamore. I will
19 refer to these documents throughout my statement.

14:13

20
21 I am three years older than P63. We were very close
22 growing up and as adults up until his death in 2021.
23 When P63 was three-months-old, our father broke his
24 back in a motorcycle accident. He was paralysed and
25 had to stay in hospital for three years. As children,
26 due to our mother's medical history and our father's
27 debilitating injury, we were in a foster home and a
28 care home. We also had to spend time with an aunt and
29 uncle until I was old enough to refuse to go into care

14:14

1 and, along with dad, we were able to stay in our own
2 home.

3
4 Along with our father, I visited P63 while he was a
5 patient in Muckamore. After our father died, I took 14:14
6 his place in attending meetings and discussions on the
7 planning of P63's move from Muckamore to his placement
8 into assisted living accommodation.

9
10 I am making this statement so that the Inquiry has 14:14
11 knowledge of accurate information on P63's experience
12 when he was a patient with Muckamore.

13
14 As a child, I did not really notice anything different
15 about P63. It was a normal life for me and that was 14:14
16 that. I was always told that P63 had 'problems', which
17 was all that I could understand as a child, and I
18 accepted that. As I grew older, though, I saw all my
19 friends doing things with their siblings and wondered
20 why P63 could not do the same things with me. That is 14:15
21 when I realised that he was somehow 'different' to
22 other brothers. It is a feeling you cannot really
23 understand unless you have a sibling with disabilities,
24 even more so if they are your only sibling. In some
25 ways, you feel like an only child, despite knowing that 14:15
26 you are not."

27
28 The next paragraph then deals with her recollections of
29 P63 when he was a child, and the circumstances of his

1 admission in 1992 which is a bit before the Terms of
2 Reference, Chair. Of course, the Panel has evidence
3 about that from the mother and the mother's friend. It
4 is your counsel's view that that doesn't add much to
5 the Inquiry's existing body of knowledge.

14:15

6
7 If I take it up at paragraph 11:

8
9 "P63 was admitted to Movilla A. The ward looked very
10 prison-like and I remember nurses would walk around
11 with a lot of keys attached to them. The ward looked
12 very sterile as there were no comfortable chairs for
13 the residents to sit on. There were no pictures on the
14 wall. I asked a member of staff why and was told that
15 due to insurance risks, pictures could not be hung on
16 the walls.

14:16

14:16

17
18 I visited P63 with my husband over other week. My
19 mother and father visited P63 weekly. P63's view of
20 the world was very black and white. If he liked
21 someone, he would cover them with love but if he did
22 not, then he would make his feelings very clear. He
23 was particularly fond of H71, who was a nurse in
24 Muckamore. He called him, H71 and H12, who was a nurse
25 in Muckamore. He also loved H471 who supported him in
26 day care as he would bring P63 to football matches.

14:16

14:16

27
28 Incontinence was an issue for P63. When he first
29 entered Muckamore, he stayed in dormitories which did

1 not offer P63 any privacy. My father raised issues
2 with this and insisted on P63 being given a room where
3 he could have some privacy should any issues arise.
4 The common room was also locked. I became aware that
5 P63 was in with sex offenders when I recognised a
6 resident if his picture in the local newspaper. It was
7 not a good environment for P63 and I noticed that his
8 language became increasingly rude. I think it was
9 because they were a group of lads together that
10 encouraged this type of chat. It was difficult seeing
11 him living in an institution; no one wants that for
12 anyone. If it had been any other place that was
13 suitable, he would not have been there.

14:17

14:17

14 P63 was very particular about his clothing and
15 cleanliness. He was able to prepare some meals with
16 supervision, and used a knife and fork independently.
17 I have attached a report at Exhibit 1 at pages 23-24
18 from his school dated January 1993 detailing P63's
19 abilities.

14:17

14:18

21
22 My husband and I visited P63 in Muckamore. In the
23 early days of his admission, we would ring Muckamore to
24 let them know that we planned to visit P63. When we
25 arrived, we found P36 to be well dressed. However,
26 over time I began to notice a change in P63's
27 appearance and abilities to do things for himself. It
28 would often take him half an hour to decide what to
29 wear. When I visited him, I noticed he was not as

14:18

1 clean or dressed as well as usual. It seemed that the
2 staff did not have time to look after him. Due to our
3 concerns, my father and I agreed to stop giving staff
4 at Muckamore notice of our visits, so we would arrive
5 without warning and ask to see P63. It would take 14:18
6 staff 15 to 20 minutes to bring P63 to meet us. Often
7 he would present in clothes and shoes that were not
8 his, and often not the right fit. My parents had
9 bought P63 lots of clothes and when we asked where they
10 were, we were told that they went missing when they 14:19
11 were sent to the laundry. Staff also said that P63 had
12 to wear other patients' clothes as he had to be changed
13 due to his incontinence. I cannot recall the names of
14 the staff who told me this as these incidents occurred
15 so regularly. P63 was interested in his clothing, and 14:19
16 when at home he could spend a long time deciding what
17 to wear.

18
19 It seemed that the staff did not have the patients or
20 time that it took for P63 to pick what he wanted to 14:19
21 wear. His reaction to them picking his clothes may
22 have caused him to act out. When this happened, P63
23 needed a strong hand to tell him to stop it. I
24 remember the younger staff were afraid him of as he
25 could be violent when an incident occurred. 14:19

26
27 From his early admittance to Muckamore, P63 lost all
28 social ability to interact in a group. He would
29 introduce himself by his full name and say he was the

1 son of my dad and mum. I bought jigsaws and dot-to-dot
2 books for him to use when he was there but staff at
3 Muckamore did not support him in completing the games.
4 As he was in a hospital setting, this meant there was
5 no continued 'schooling' in either education or social 14:20
6 aspects. Unfortunately, his isolation increased as
7 aunts and uncles found it traumatising to visit him in
8 Muckamore due to the noise of patients banging on doors
9 that were locked. Eventually, they stopped visiting
10 P63, except for an aunt and uncle that he called 14:20
11 Princess and Big Eddie.

12
13 The setting in Muckamore prevented P63 from being
14 socially active with his extended family who he grew up
15 with. Attached at Exhibit 2 at pages 25-27 is a 14:20
16 document completed by Muckamore called Person Centred
17 Planning Based assessment P63. That was prepared
18 following my father's official complaint on 16th April
19 1998. I refer this letter in detail at paragraph X. A
20 copy of relevant correspondence and the plan is 14:21
21 enclosed.

22
23 One of the most important factors recorded is how
24 important his family members were to him, including his
25 parents, me, my husband and children, aunts and uncles 14:21
26 and his granny. I believe that the lack of contact
27 with his family due to their not wishing to visit P63
28 in Muckamore negatively impacted P63.

1 I remember visiting P63 one time with my children when
2 they were young and, when we arrived, P63 was naked. I
3 spoke to a member of staff, I cannot recall their name,
4 and asked why P63 was naked. I was told that he
5 refused to put on his pyjamas, and no further 14:21
6 explanation was offered. I got P63 to put on his
7 pyjamas. On other occasions we would arrive to visit
8 to find him naked in bed, and were told that he refused
9 to get changed after a shower. I stopped bringing my
10 children to Muckamore as they got older and became more 14:22
11 aware of the surroundings, as it was not the best
12 environment for them.

13
14 There was a lack of care for P63's basic living needs.
15 A podiatrist attended Muckamore every 4-6 weeks to cut 14:22
16 his fingernails and toenails. P63 did not like the
17 podiatrist to cut his nails. I was the only person
18 that he would allow cut his toenails, so I would do
19 this for him when I visited. When P63 lived at home he
20 kept his hair short, known as a 'number 2'. When he 14:22
21 was in Muckamore, his hair was not maintained so my
22 husband cut it for him.

23
24 P63 thrived around female company when he lived at
25 home. When he was first admitted to Muckamore, he was 14:22
26 surrounded by men, both patients and staff. We told
27 staff at Muckamore that he would settle well if there
28 was more engagement with female staff. However, this
29 did not happen. I do not remember the names or details

1 about the staff members who I spoke to."

2
3 In the following paragraphs then, Panel, from 19
4 through to 28 inclusive, there's a lengthy discussion
5 about correspondence in the period from 1994 to 1998, 14:23
6 which predates the Terms of Reference. I don't propose
7 to read it out in detail.

8 CHAIRPERSON: No, but it may be worth mentioning that
9 at paragraph 23, she refers in some detail to a letter
10 written dated 16th April 1998, which must be the letter 14:23
11 that she's referring to in paragraph 15 as paragraph X.

12 MR. McEVOY: Yes. So, that's a letter from P63's
13 father to H90.

14 CHAIRPERSON: That is H90, is it? Instead of paragraph
15 X, we need to put in paragraph 23. 14:23

16 MR. McEVOY: Yes.

17 CHAIRPERSON: All right. Okay.

18 MR. McEVOY: So, if it's in order then, Panel, I'll
19 take it up at paragraph 29.

20
21 "As set out in my mother's statement, there were times
22 when P63 was manhandled. P63 got black eyes. He got
23 bite marks from other patients but surely that is to be
24 expected under the circumstances. There were occasions
25 where he would had to have been manhandled, but when he 14:24
26 was at his worst. He was as strong as an ox and the
27 only way to get him out of a situation was to move him
28 with some force. The end result might have been some
29 bruises but there was no other way. To any outsider

1 this may seem extreme but unless you have lived with a
2 son, daughter, sibling with learning disabilities to
3 this extent, you simply cannot understand. P63 also
4 gave others many bruises, bites and black eyes during
5 his time at Muckamore.

14:25

6
7 When P63 blew up, he would lash out with superhuman
8 strength, and force was required to settle him. When
9 this would happen with me, I had to give him a bear hug
10 to help him settle. When my father would see the marks 14:25
11 on P63, he would raise the issues with staff at
12 Muckamore. My father did not give me a lot of detail
13 but he was a strong advocate for P63 and usually
14 resolved any" -- I think it is supposed to be "any
15 issues arising."

14:25

16
17 "We, as a family, had many issues with Muckamore over
18 the years. Many have already been put before the
19 Inquiry through copies of letters written by our
20 father. Some had satisfactory responses and some did 14:25
21 not. As a family my dad, mother, my husband and I
22 would often get together to discuss issues with each
23 other when they arose. When P63 was on Movilla A, we
24 usually met him in a visitor's room. As P63 had his
25 own room by this time, we asked to see him there but we 14:25
26 were told that we could not go to the room to protect
27 other patients' privacy. We did not believe this to be
28 true as we did have the opportunity to see him in his
29 room on occasions, and it was not a homely or safe

1 environment for him. The bed was up against a wall,
2 which had no headboard. I could see where P63 had made
3 a dent in the wall from resting his head against it.
4 We insisted that a headboard be added to the bed, and
5 Muckamore did so. There were rarely sheets on the bed 14:26
6 and when we asked why, we were told this was due to
7 P63's incontinence issues. There were no curtains on
8 the window as staff said P63 pulled them down. The
9 room was very like a hospital setting.

10
11 I remember that there was a television in P63's room
12 that was behind glass. P63 loved to watch Transformers
13 and Airwolf DVDs in his room. At home he was able to
14 change the DVDs but as the television was behind glass,
15 he needed someone to change them for him so he had to 14:27
16 call staff every hour to change them. When no one
17 came, this would upset P63 and cause him to become
18 distressed and act out.

19
20 There were times when we visited P63 on the Movilla A 14:27
21 ward to find that he had been placed in a room that was
22 not his bedroom. When we asked why, we were told that
23 the staff had to put him there as he had blown up. I
24 believe that the room may have been used as a seclusion
25 room. The room was near the entrance to the ward and 14:27
26 had a window that P63 could look through. If the staff
27 at Muckamore determined that P63 had not calmed down,
28 they would refuse to let us see him so we had no option
29 but to leave. I am unable to confirm who told us this

1 as there were different staff at different times on the
2 ward.

3
4 I remember uniforms were not worn for most, if not all,
5 of the time P63 was in Movilla. When this happened, 14:28
6 P63 was able to see us leave, which upset him further.
7 I accept if P63 acted out, that he would throw a jug of
8 water, torn down curtains off the wall or pull the
9 cistern off the wall and needed to be isolated so he
10 could calm down, but I felt that the seclusion room was 14:28
11 used too often. We discussed this as a family and if
12 we felt it was necessary, dad, being the head of the
13 family, would speak to staff or write an official
14 letter. The contents of some of these letters are
15 referred to throughout my statement and exhibited where 14:28
16 relevant.

17
18 When he moved to the Killead Ward, we visited him in
19 his room. I cannot recall when P63 moved to this ward.
20 When he was first admitted to Killead, he stayed on the 14:28
21 ward with both male and female patients. The ward
22 changed to male-only patients, however I cannot recall
23 when.

24
25 Throughout P63's time in Muckamore, my father and 14:29
26 mother would ring Muckamore every evening for an end of
27 day report. My father would update me but he did not
28 say who he spoke with. I understand that the report
29 would have been read out over the phone by either the

1 staff in charge in that day or whoever answered the
2 phone, as they would have read from the 'logbook'.

3
4 There were many times when my father and I visited P63
5 in the evening when I had finished work to find that he 14:29
6 was in bed before 6:00 p.m. We were told that P63
7 wanted to go to bed and that he could not now leave his
8 room. We had no option but to go home. This happened
9 on both Movilla A and Killead, but more often on
10 Killead. 14:29

11
12 When P63 was at home, he usually went to bed around
13 8:00 p.m. However, in Muckamore he seemed to be put to
14 bed by 6:00 p.m. and remained in his room in silence
15 until the next morning. I do not know why the staff 14:30
16 put P63 to bed so early in the evening but I think it
17 may have been done to help the night staff. However, I
18 do not think it was in P63's best interests to allow
19 him to go to bed so early, even if he wanted to.

20 14:30
21 On occasion, P63 would visit our parents at home for a
22 few hours. The ability for P63 to come home depended
23 very much by staffing levels and the availability of
24 transport. Due to P63's needs, two members of staff
25 from Muckamore were to travel with him by minibus to my 14:30
26 parents' house. When P63 travelled in a car, there was
27 a risk that he could reach out and grab the driver if
28 he was triggered. This happened a number of times when
29 my father was driving the car; this was very dangerous.

1 There were times when my parents would ready the house
2 for his arrival but he did not come. Sometimes someone
3 from Muckamore would notify my parents that morning to
4 say that P63 would not be coming home, but there were
5 times when they did not, so my parents would ring 14:31
6 Muckamore to be told that there was no transport
7 available as it broke down, or another ward booked it,
8 or no staff were available to travel with P63. P63
9 looked forward to coming home and when he found out
10 that he could not, he became very upset. Sometimes P63 14:31
11 was only able to stay for a little while but it made
12 him happy.

13
14 To support P63, some staff at Muckamore agreed to
15 travel with him in my parents' car for short journeys 14:31
16 outside Muckamore, but they could not continue to do so
17 due to insurance risks. My parents could only take P63
18 and the member of staff for a drive around Muckamore
19 grounds. I do not know their names, as my parents
20 dealt with them directly. My father had no option but 14:31
21 to pay for a bus service for P63 to visit home. It is
22 bad when a patient cannot visit his parents because the
23 hospital do not have the staff or cannot pay for the
24 transport.

25 14:32
26 P63 was unable to live in the community without
27 full-time care and support. The Trust tried to
28 resettle him in residential care. However, he was
29 unable to stay as the support staff could not manage

1 him when he was triggered. I cannot recall the names
2 of the care homes or the Trust that they fell under.

3
4 When we first became aware of the abuse claims linked
5 to Muckamore, we, as a family, sat down and discussed 14:32
6 the situation and not one of us then even contemplated
7 that our P63 would be among the victims. We continued
8 to discuss it further over the years following, and not
9 once did any of us feel P63 was abused. I can say I
10 never saw actual abuse first-hand. What I mean by this 14:32
11 is staff being unnecessarily rough. There have been
12 occasions I have not liked the way in which something
13 was done or handled but not to the extent I would call
14 abuse. For example, one of the family's pet hates was
15 the fact that despite being told on many, many 14:33
16 occasions that P63 was known as P63, the staff would
17 call him by his nickname. This would confuse P63 and
18 would cause problems with his behaviours. At times
19 staff, who would be inexperienced and younger than P63,
20 would be put 'on him' as his one-on-one, and they would 14:33
21 be afraid of him. P63 could read this and straightaway
22 that put him into a position where he did 'blow'. The
23 inexperience of how that staff member would handle the
24 situation was all wrong, and this would make P63 more
25 distressed which often led to him being put into a 14:33
26 seclusion room. If his reactions had been handled
27 differently, this would not have happened.

28
29 His state of dress on any given day would depend on

1 what staff was assigned to him. Mostly was okay but
2 others simply did not care. When P63 felt
3 uncomfortable, this could cause his anxiety and
4 behaviours to heighten. With P63, sometimes the best
5 way was simply to step back. On other occasions when
6 P63 had a particularly bad time, he would need
7 restrained and the only way to do was to keep in a hold
8 position like a bear hug from behind. At times P63
9 would just need someone to tell him to settle down, as
10 he was like a young child.

14:34

14:34

11
12 If we thought that P63 was being abused in Muckamore,
13 we would have done something about it. We loved P63
14 dearly, and simply would not have sat back if we
15 thought he was in any danger or being mistreated. This
16 is why this came as a total shock when I heard about
17 BBC News report mentioning him by name.

14:34

18
19 My father was an advocate and champion for P63 up until
20 he passed away in 2017. My father's passing was very
21 hard on P63. He cannot understand that our father was
22 no longer with us and when I explained that he was in
23 heaven, P63 asked when he was coming back. After my
24 father's death, I attended meetings and advocated for
25 P63.

14:35

14:35

26
27 I cannot recall the year when this happened, but
28 Muckamore began to explore the possibility of moving
29 P63 out of Muckamore to" a facility in a town. "I

1 attended meetings in Muckamore with district nurses,
2 Social Services, consultants, and other representatives
3 from Muckamore. I found this process to be eye-opening
4 as it involved many people to include consultants, ward
5 staff, speech and language therapists, district 14:35
6 nursing, care home staff. They discussed what role
7 district nursing and GP would have when P63 was
8 resettled. The care home staff would be briefed on his
9 daily routine and what facilities, such as activities,
10 should be in place for P63 when he moved; how family 14:36
11 visits would be conducted, etc. These meetings were
12 to make sure all health and safety precautions were in
13 place, that P63's transition was made as easy as
14 possible.

15 14:36
16 I believe that P63 moved to another facility in 2018.
17 I cannot recall exactly when. By this stage of his
18 life, P63 had been resident in Muckamore for 26 years
19 and I had become very institutionalised as the day rang
20 to fixed time. One of the biggest changes to his day 14:36
21 was no longer leaving the building to attend the day
22 centre. When he was in Muckamore, he walked to the day
23 centre. However, in the new facility, the day centre
24 was a room within the building. When P63 attended the
25 day centre in Muckamore, he called it going to work as 14:36
26 he left the building. To help him, the new facility
27 would bring P63 to the room by taking him out through
28 one door and bringing him in through another. To help
29 P63 to adapt to the changes in his day in that new

1 facility, staff from Muckamore stayed with him during
2 the day approximately two weeks, by which time he had
3 settled in well. P63's relocation to that facility was
4 five minutes from my work so I was able to call in to
5 see him easily.

14:37

6
7 I often took P63 out for the day. I could not take him
8 to places where there were lots of people but he
9 enjoyed visiting open farms at quiet times. He enjoyed
10 a KFC on his days out as he thought Colonel Saunders
11 looked like our father. At Christmas time we would
12 drive around Antrim looking at the Christmas lights.

14:37

13
14 In my opinion, it was the systems in place and the lack
15 of a more homely environment that let my brother down
16 over the years, coupled with the lack of a more
17 suitable placement that could cope with his condition.
18 I am not sure if the PSNI investigation will find any
19 wrongdoing against my brother. I sincerely hope not.
20 However, if so, I am sure the Inquiry will make the
21 right choices moving forward to allow abuse to be
22 brought to a full stop but also to perhaps open some
23 eyes to the lack of facilities, other than Muckamore,
24 for people like P63. They are people too, just a
25 little more special than you or me and deserve a little
26 more special care."

14:38

14:38

27
28 CHAIRPERSON: All right. Thank you to P63's sister who
29 I imagine is watching. We'll move on to the next

1 statement.

2 MR. McEVROY: Ms. Tang is going to deal with that.

3 CHAIRPERSON: Do we need time for anyone to log on?

4 Thank you.

5 MS. TANG: Good afternoon, Chair, good afternoon, 14:39

6 Panel. The next statement relates to P120's father.

7 The statement is dated 31st August 2023. There are no

8 exhibits with the statement.

9 CHAIRPERSON: Thank you.

10 MS. TANG: The internal page reference number for the 14:39

11 statement is 1391.

12

13 "I, P120's father, make the following statement for the

14 purpose of the Muckamore Abbey Hospital Inquiry.

15 14:39

16 My connection with Muckamore is that my son, P120, was

17 a patient at Muckamore. The relevant time that I can

18 speak about is between 2010 and 2014.

19

20 I am the father of P120. P120 is 29 years old, having 14:39

21 been born on" the date of birth is redacted. "P120 has

22 one brother", whose name is redacted, "who is three

23 years older.

24

25 P120 is currently a patient in" a facility in England, 14:39

26 the name of which is redacted, "where he has been since

27 2014.

28

29 P120 was diagnosed with epilepsy after a seizure at

1 home when he was a young child. I think that he may
2 have been hospitalised for a period, likely at the
3 Royal Belfast Hospital for Sick Children. During this
4 period, P120 was prescribed medication for his epilepsy
5 and for his behaviour more generally.

14:40

6
7 Sometime later, P120 was diagnosed with autism and
8 ADHD. P120 attended a mainstream primary school, but
9 due to his behaviour and specific needs it was felt
10 that this was not best suited and so P120 attended"
11 another name redacted, "special school in Belfast
12 letters. P120 was happy at that facility. He attended
13 that facility for a number of years but I cannot recall
14 how long exactly.

14:40

15
16 P120's behaviour was generally quite good until he went
17 to MAH. P120's behaviour had deteriorated before his
18 admission but it definitely worsened whilst he was in
19 MAH. P120 became aggressive. He would not want to
20 leave shops, would fall to the ground, and refuse to
21 leave. P120 would hit out. Social workers from the
22 Belfast Health and Social Care Trust (BHSCT) became
23 involved when P120's mum left. The senior social
24 workers were H494 and H495. P120 was taken into care
25 for periods."

14:40

14:41

14:41

26
27 CHAIRPERSON: Can you make sure you keep your voice up?
28 MS. TANG: Yes, sorry. I will do.

1 "P120 went to a [restricted location] hospital in
2 Belfast. Thereafter, he attended", the name of another
3 facility which the name is restricted, "in Belfast,
4 which is a home offering accommodation for children
5 assessed as presenting emotional, behavioural or 14:42
6 educational difficulties. P120 then went to reside in
7 the Iveagh Centre, which in 2010 replaced the services
8 provided by the Children's Unit in MAH. I would have
9 visited Iveagh but I cannot recall how the move to MAH
10 came about. 14:42

11
12 "P20 was admitted to MAH in 2010 when he was 15 years
13 old. I am not sure whether P120 was formally detained
14 at that time but the admission may have been made
15 through a court order. I was not told how long P120 14:42
16 would remain in MAH. The plan for P120's admission was
17 never explained to me.

18
19 I was never invited to meetings at MAH regarding P120
20 and his care. MAH were only in contact when they 14:42
21 needed something. I may have received the odd letter
22 via post. If it had been an invitation to a meeting, I
23 would have attended.

24
25 P120 was permitted to come home at the weekends so I 14:43
26 did not have visits with him at MAH. I would have
27 collected P120 from MAH and returned him there at the
28 end of his visit home. It was a nightmare when
29 returning P120 to MAH. He didn't want to be there.

1 P120 would cry and say that he did not want to go back.
2 He would refuse to get out of the car, fall to the
3 ground, and say that staff were hurting him and putting
4 him in the naughty corner, which I later learned meant
5 the seclusion room. P120 seemed afraid to me, it was 14:43
6 heartbreaking to watch and to have to send him back.
7

8 On one occasion when I was returning P120 to MAH, I saw
9 a staff member grabbing him to bring him back inside.
10 I think I reported this matter to the PSNI. However, I 14:43
11 cannot be certain given the passage of time.
12

13 P120 loved being at home. He enjoyed getting hot
14 showers and using my aftershave. P120 loves being
15 clean. When he was getting a bath, there would have 14:44
16 been bubbles up to the ceiling. P120 loved his food,
17 and got on well with his brother", whose name is
18 redacted. "He enjoyed spending time at home with his
19 family. P120 had his moments at home too, but we could
20 manage them. At times I would have to phone the social 14:44
21 worker for emotional support, but I found that this
22 often made matters worse for P120.
23

24 P120 told me about the seclusion room in MAH. P120
25 told me that on one occasion he was put into the corner 14:44
26 of the seclusion room, slapped across the head and had
27 cold water thrown on him. He said that it was a padded
28 room and staff would call it the Naughty Corner. I
29 believe that it was used as a punishment. P120 would

1 be sat in a single chair and locked in the seclusion
2 room. P120 cried to get out. The staff would say that
3 P120 was being very bad. P120 was subjected to the
4 seclusion room many times. No staff member at MAH ever
5 explained what the seclusion room was all about.

14:45

6
7 I went to the Sunday Life newspaper to raise awareness
8 of this. P120 had already been sent to England by this
9 stage under an extra-contractual referral or ECR as,
10 apparently, there was no suitable placement in Northern
11 Ireland for him. I also spoke about this with Nigel
12 Dodd, who was then an MP.

14:45

13
14 P120 was heavily medicated at MAH. At times P120
15 appeared completely out of it and spaced out. I threw
16 the tablets back at staff on one occasion and I believe
17 that the staff called police on me because of this.

14:45

18
19 I saw marks on P120's body, and bruises. When I
20 queried these marks, the staff would tell me that P120
21 fell, or that he did it to himself. P120's aunt who
22 would not visit but would drop him off at MAH, saw P120
23 being roughly handled by staff. I reported my concerns
24 to P120's social workers, H494 and H496, but they did
25 not nothing. They would say it was terrible but did
26 not assist in any way. I felt I had no other choice
27 but to go to a solicitor and report the matters to the
28 police.

14:45

14:46

1 I did not have much contact with P120 when he was in
2 MAH. However, my view is that P120 became more violent
3 throughout his time at MAH. I made a formal complaint
4 to MAH about this but I do not believe that anything
5 was ever done.

14:46

6
7 Eventually, I was told by MAH staff that they
8 considered P120 was too violent and would need to be
9 transferred to another facility. I believe that there
10 was some kind of court process by which P120 was
11 transferred to England. I do not recall being involved
12 in the decision. P120 was transferred to the facility
13 in England in or around 2014. I understood P120 would
14 be in England for a six-week assessment, but he has
15 been in England ever since.

14:46

14:47

16
17 P120 seems to have improved. He does not lash out now
18 and is desperate to come home. During telephone calls,
19 P120 repeatedly asks, 'Daddy, when am I coming home?'
20 This makes me extremely upset as I have no answer for
21 my son. I am not able to get to England frequently.
22 Whilst I speak to P120 on the telephone, it is no
23 substitute for having him home. I last saw P120 in
24 person on his birthday in 2022. There was no privacy
25 given to us during this visit. I have engaged with
26 Mencap to try and get advocacy services.

14:47

14:47

27
28 The family and I very much want P120 home. I am
29 heartbroken and I am in the process of issuing court

1 proceedings to compel P120's return to Northern
2 Ireland. Shortly before Christmas 2019, I met with the
3 BHSCT to discuss my concerns. During that meeting I
4 was told that P120 would be brought back in January
5 2020 to a placement in Lisburn. I was content with
6 this proposed placement. However, P120 remains in"
7 redacted named facility, "and I have no idea when he
8 will be returned to Northern Ireland."

14:48

10 The witness then indicates his preferences regarding
11 giving evidence to the Inquiry and provides a
12 declaration of truth.

14:48

13 CHAIRPERSON: Again, can I thank P120's father, who I
14 know is sitting at the back of the room, very much for
15 that statement. Thank you.

14:48

16 MS. TANG: Thank you, Chair.

17 CHAIRPERSON: If you'd like to go with the secretary to
18 the Inquiry out the back door. Thank you very much.

19 MS. TANG: Chair, I wonder if we could have a short
20 break just to allow the next witness to join by Zoom?

14:48

21 CHAIRPERSON: Yes, okay. I think we'll just sit here
22 and just do some reading while we wait because I think
23 the secretary will be back. Every time we rise, it
24 takes about ten minutes to get back in so it's better
25 if we just sit. Is the next witness P124?

14:49

26 MS. TANG: The next witness is P129's brother. Then
27 following that, Chair, will be P124's mother, and the
28 final statement of the day will be in regard to P127.

29 SHORT PAUSE IN THE PROCEEDINGS

1
2 MS. TANG: I may have misinformed you in relation to
3 the running order.

4 CHAIRPERSON: I thought so because I thought actually
5 the next one was P124. 14:50

6 MS. TANG: Yes. Ms. Briggs will be reading in with
7 that statement. My apologies.

8 MS BRIGGS: Chair, members of the Panel, I am told that
9 P124's mother is logged on so we're in a position to
10 read that statement now. 14:51

11 CHAIRPERSON: Hold on a second. Okay. So, welcome to
12 P124's mother. The statement is now going to be read.

13 MS. BRIGGS: Yes, and we can call P124's mother by her
14 first name, which is Tracey. The statement reference
15 is ST1-142-1. 14:51

16
17 Picking up then, Tracey says:

18
19 "My connection with MAH is that I'm the mother of P124
20 who was a patient in MAH. The relevant time period I
21 can speak about is 1995 to 23rd March 2020. 14:51

22
23 I am the mother of P124, who is now 39 years old. P124
24 currently lives with me, his younger brother and his
25 father. 14:52

26
27 P124 suffers from several disabilities and other
28 difficulties, which is the consequence of a traumatic
29 birth. He did not meet his developmental milestones.

1 He has a significant learning disabilities and lacks
2 capacity. He also has significant behavioural issues
3 relating anxiety that can give rise to obsessive and
4 aggressive behaviours, as well as self-harm.

14:52

6 P124 is verbal and can communicate well. He can have a
7 conversation. However, due to P124's learning
8 disability, he can misinterpret certain things that
9 would be said to him and may not fully understand
10 everything. This can cause him to feel elevated levels
11 of anxiety. For example, P124 is not always able to
12 say when he is in pain or specify where his pain is
13 coming from. P124 will sometimes communicate by a
14 physical demonstration. It is important to learn about
15 how P124 communicates and to be sensitive to that.

14:53

17 When P124 was one year old, he started having febrile
18 convulsions which then developed into epilepsy. P124's
19 treating consultant at that time advised it would be
20 best to start P124 on Epilim to help with the seizures.
21 P124 was prescribed Epilim up until he was 5 years old.
22 By that age, P124 had stopped having seizures and the
23 consultant then felt that P124's seizures were under
24 control.

14:53

26 When P124 was around four years old, the consultant
27 referred him to a specialist learning disability
28 consultant due to the behaviours that P124 had been
29 displaying. For several years we went back and forth

14:53

1 between many professionals. Unfortunately for P124, it
2 seemed that these professionals were not sure how best
3 to support P124. P124 attended a hospital to meet with
4 consultant H250. H250 expressed the view that P124 was
5 'unique' and that she did not know exactly how to move 14:54
6 forward with him. P124 was then diagnosed with severe
7 learning difficulties together with severe behavioural
8 problems when he was around five years old.

9
10 P124 attended a", named school in a town, which is 14:54
11 redacted, "when he was around five years old but this
12 placement had broken down within one year or so because
13 the school could not cope with P124's behaviours.
14 Thereafter, P124 attended a different school, also in
15 the same town, when he was around five or six years old 14:54
16 until the age of 11 years old. During P124's time in
17 that school, P124's behaviours worsened.

18
19 P124 was first admitted to MAH when in 1995 when he was
20 aged 11. This had been proposed by his consultant at 14:54
21 the time, H250, and supported by the social workers.
22 It was suggested because of the placement in his school
23 had broken down and we were struggling at home with
24 P124's behaviour and aggression. I was told that P124
25 would be going to MAH initially for an assessment which 14:55
26 would take about six weeks.

27
28 P124 was admitted to Conacre Ward which was for
29 children. Our family found his admission traumatic.

1 My mum, dad and I took P124 to MAH. I had hoped that I
2 would be able to stay with P124 and settle him into his
3 bedroom. However, I was advised that I was not allowed
4 to go onto the ward, and we were told to leave. This
5 was extremely difficult for me and my parents as we did 14:55
6 not want P124 to feel that we had abandoned him. P124
7 was crying and was asking me not to leave. I became
8 greatly distressed by this and I struggled to leave
9 him.

10
11 I was never allowed on to the ward and I was never able
12 to see where exactly P124 slept every night, even as a
13 child. Every time I asked to go on to the ward, I was
14 refused. Instead, we were sent to a 'family room' for
15 visit. It was at the end of an old, dark hallway 14:56
16 leading to a room. The room itself was dark, having
17 only high square windows which barely let any light
18 through. I would have referred to this room as a jail
19 cell. It was not an appropriate room for family visits
20 with children in MAH. 14:56

21
22 P124 ended up being in MAH for a period of six to nine
23 months instead of the original six weeks that had been
24 advised to us. I was told that they were trying to
25 sort out his medication. I was also advised that P124 14:56
26 was attending daily behavioural therapy with a nurse
27 which needed to continue, and that once his treatment
28 plan had been completed, he could then come home.
29

1 I would have visited P124 a couple of times a week. I
2 would have taken P124 for walks around the grounds of
3 MAH. I would have brought our family dog, Cindy, with
4 me so that P124 could see her. I was not allowed to
5 leave the hospital grounds with P124.

14:57

6
7 After a few weeks in MAH, I noticed that P124 had
8 bruising to his neck and I asked him how this happened.
9 P124 was able to role play this with his father. He
10 showed that he was being held down with a foot on his
11 neck. He did this consistently. P120's father and I
12 complained to the Ward Manager, H122. MAH staff
13 investigated. No explanation was ever given to us as
14 to how P124 suffered bruising to his neck as a child.
15 We then went to see senior management, H77, and another
16 male staff member who was, I believe, higher up than
17 H77. They all said they did not know how it happened.
18 Nothing was done.

14:57

14:57

19
20 This period in MAH did not seem to make any difference
21 to P124's behaviours and difficulties. P124 was still
22 the same after six to nine months. He was still
23 displaying elevated levels of anxiety and elevated
24 levels of aggression. P124 was prescribed Risperidone
25 upon his discharge, which was to apparently take the
26 edge off his aggression, along with Tegretol. There
27 was also other medication prescribed which we were told
28 was to stop P124 from having thoughts of a sexual
29 nature. I questioned why they were stopping this as

14:58

1 P124 was displaying traits of a typical 14-year-old
2 teenager. I was advised by MAH that those sexual
3 thoughts were causing aggression and therefore it was
4 necessary to medicate him. I was never made aware of
5 any possible side-effects.

14:58

6
7 P124 had also developed a fair of MAH and was
8 completely petrified of the thought of having to go
9 back there. The fear of potentially having to go back
10 to MAH was, in fact, enough for P124 to moderate some
11 of his specific behaviours.

14:58

12
13 We managed P124 at home for nearly ten years, save for
14 a period when P124 was 15 years old and admitted to
15 MAH. This was a struggle but we managed with the
16 assistance of respite and day care.

14:59

17
18 In 1999, when P125 was 15 years old, he was admitted
19 back into MAH. I believe he went back on to the
20 Conacre ward. P124 was readmitted as our family was
21 finding it increasingly difficult to manage P124 at
22 home, and his placement at his school had broken down
23 again.

14:59

24
25 At that time I was told that MAH would be completing
26 more assessments on P124 and would tweak his
27 medication. P124 was in MAH for around another nine
28 months. Again, we were not allowed to see P124's
29 bedroom or living area. As before, we were only

14:59

1 allowed to spend time with P124 in one specific small
2 room that had square windows and barely any light.

3
4 I recall an incident whereby P124 was out for a walk
5 with staff and he had requested help to walk up a hill 15:00
6 as his eyesight would not be the best and he is quite
7 unsteady on his feet. P124 told me that staff refused
8 to help him. P124 again role played that he had to get
9 down on his hands and knees and crawl up the hill,
10 which is why he was so dirty. He was still dirty when 15:00
11 he was on the ward as staff did not change him when he
12 had returned to the ward.

13
14 P124 was allowed home after around nine months with
15 more medication. There was still no change to P124's 15:00
16 behaviour when he returned home. If anything, his
17 behaviour had deteriorated further. The ward that P124
18 was in during this period was subsequently knocked
19 down. It was a ward building beside Erne and it was
20 universally referred to by people as MAH as the 15:00
21 'lock-up'. This was Ward.

22
23 Between 2000 and 2007 P124 attended a day care and
24 respite centre. During this time things at home always
25 remained quite difficult. The care service found it 15:01
26 definite at times to manage P124 in this period. The
27 care service advised that P124 had to go somewhere else
28 as they could not offer him any further respite due to
29 his behaviours. The BHSCCT wanted to return P124 to MAH

1 because if P124 could not go to the care service, then
2 there was nowhere else where he could go.

3
4 In or around April 2007, when P124 was about 23 years
5 old, he was admitted to MAH and initially placed into 15:01
6 PICU. I was told once again that P124 would undergo
7 further assessments in MAH. P124 went into Cranfield.
8 This admission happened around the time that P124's
9 grandmother had died. This had a massive impact on
10 P124 and me. P124 had already experienced the death of 15:01
11 his grandad when he was in his late teens. P120
12 manifested his distress over his grandmother's death
13 about an increase in his aggressive behaviours. P124
14 does not know how to control or express his emotions
15 and one way in which he expresses his emotions is 15:02
16 through his aggression.

17
18 In December 2007, we had P124 at home for a visit and
19 discovered that he had a large bruise from hip to knee.
20 I asked P124 what had happened. Again, he did role 15:02
21 play with P124's father, demonstrating what had
22 happened. P124 played the role of a carer and flung
23 P124's father against the door frame saying 'Get in' in
24 a cross and angry tone of voice. P124 named this carer
25 as H470. Upon returning P124 back to MAH, I asked the 15:02
26 ward staff for an explanation for this massive bruise
27 and for an investigation to be carried out.

28
29 Thereafter, a meeting was held with H77, the hospital

1 Operations and Therapeutic Services Manager, as well as
2 a few other professionals and social workers. H77's
3 son also worked in MAH as a care worker in the day care
4 unit. At the meaning we asked for an explanation as to
5 where the significant bruise had come from and how it 15:03
6 happened. We explained to the staff what P124 had role
7 played for us at home. H77 and other professionals
8 advised 'We just don't know what happened to P124.' I
9 reminded them that P124 was in their care when he
10 sustained this injury and so they should know what 15:03
11 happened to him. H77 said, 'Well, I can't, we don't
12 know'. P124's father pointed out to H77 that staff
13 must have seen what had happened as there was a night
14 station that observed the whole room. H77 advised that
15 his staff did not see what happened to P124. 15:04
16 Ultimately the meeting ended as we were nothing getting
17 any further explanations from the staff.

18
19 We made an official oral complaint to the Belfast
20 Health and Social Care Trust, and the PSNI were 15:04
21 contacted by MAH at our request. I believe that P124
22 was interviewed by police but that the PSNI concluded
23 that he lacked capacity to give evidence.

24
25 I believe that P124 was detained when he went into MAH. 15:04
26 This was for a few years. I was not aware of any
27 reviews of his detention before any tribunal. I was
28 only ever told that P124 was being held under the
29 Mental Health legislation. I recall trying to take

1 P124 on holiday and being refused because he was a
2 detained patient. However, because this was never
3 actually explained to me, I did not realise that I was
4 not permitted to take P124 out of MAH. I was never
5 informed of Mental Health Review Tribunals, nor was I
6 involved in any Mental Health Review Tribunals.

15:04

7
8 Notwithstanding his detention, P124 would routinely
9 have been allowed to come home for Christmas. I would
10 have picked him up on Christmas Eve and then returned
11 the day after Boxing Day. However, I believe that for
12 Christmas 2011, P124 was not allowed to come home. I
13 challenged this with the ward manager. He would not
14 listen even though I told them that P124 had always
15 been allowed to come home for Christmas. I made
16 alternative arrangements and P124 was only allowed home
17 for Christmas Day for dinner and he had to be returned
18 to MAH that evening.

15:05

15:05

19
20 Following the Bamford Review and recommendations that a
21 specific number of patients must be resettled into the
22 community by a specific timeline, I can recall I was
23 then informed that P124 was no longer detained under
24 the Mental Health legislation.

15:05

25
26 Around 2012, P124 came home for a day visit and I
27 noticed his ankle was swollen. MAH staff advised that
28 he had tripped. I asked why he was not taken to A&E.
29 I took him to A&E and discovered that his ankle was

15:05

1 broken. I requested for this failure by MAH staff to
2 be investigated further but I did not hear anything
3 more about it."

4
5 Chair and Panel, the next paragraph I'm not going to 15:06
6 read that in with reference to the MoU. I'm going to
7 skip on then to paragraph 31.

8 CHAIRPERSON: That's paragraph 30?

9 MS. BRIGGS: That's paragraph 30, Chair.

10 15:06
11 "In or around 2013 I received a call to say that MAH
12 has to take P124 to Antrim Area Hospital due to
13 injuries sustained from head-banging. One of his eyes
14 became unresponsive due to this. P124 did have a known
15 history of head-banging. I remember asking H 40 if 15:06
16 P124 could wear a helmet to protect him but I was
17 advised that it would not be suitable for him because
18 he would just take it off. I queried why this was not
19 even tried. I can recall times where P124 would have
20 been head-hanging in MAH and the staff would have 15:07
21 observed him through a window and allowed P124 to
22 continue banging his head, even though he was obviously
23 injuring himself. When they thought that P124 was
24 doing this for too long, this is when they would have
25 stepped in and tried to distract P124. At this point 15:07
26 P124 would have already sustained significant injuries
27 to his head. P124 now has an egg-shaped formation to
28 the front of his forehead from his time spent in MAH.
29 I would have complained about this a lot but it always

1 fell on deaf ears. I felt like I was continuously
2 ignored.

3
4 In or around 2018 or 2019, P124 had a bruise to his arm
5 which was explained as resulting from an altercation 15:07
6 between P124 and a nurse. The PSNI were aware of this
7 and I was interviewed in a police station. The police
8 said that there was nothing on CCTV. I made a
9 complaint to the safeguarding officer within MAH, H283.
10 H283 met me at the administration building in MAH. 15:08

11 P124 had role played to us that he was out for a walk
12 outside Erne Ward when P124's staff member, H467, had
13 asked another staff member to stay with P124 while she
14 got a cup of tea. P124 was not familiar with the male
15 staff member and P124 said to him, 'I'm going to kick 15:08
16 your car.' The male staff member then said to him
17 'You're not going to hit my fucking car', and twisted
18 P124's arm behind his back. When H467 returned, P124
19 hold H467 that the male staff member had hurt him.

20 H467's response was to deny this. This incident 15:08
21 occurred roughly 10 to 15 minutes before I arrived to
22 collect P124 to take him out for the day. On arrival,
23 P124 had told me what had happened. Again, H467's
24 response was to say, 'No, P124, that didn't happen'.

25 It was later that day that I then noticed a bruise 15:09
26 appearing on P124's arm. The PSNI investigated this
27 and reviewed the CCTV, but this incident occurred
28 outside of the areas covered by CCTV. Therefore,
29 police considered that there was not enough evidence to

1 take matters further.

2
3 In or around the same time in 2018 or 2019, P124 and I
4 were having a nighttime call. P124 was saying some
5 quite unpleasant things to another member of staff, 15:09
6 H468, who was pregnant at that time. P124 accidentally
7 left his phone on when they had finished their call so
8 I could hear what was happening in the background. I
9 heard another member of staff present, called H469,
10 engage in very angry verbal abuse to P14 including, 15:09
11 'How dare you. You are horrible.' I heard this over
12 the telephone and made a complaint. H469 made an
13 apology and she subsequently left MAH.

14
15 In 2019 we collected P124 from MAH for the weekend to 15:10
16 go to our caravan. The staff told me that P124 had not
17 slept, which was unusual for him. He seemed to be in
18 pain. I gave him some paracetamol and thought the pain
19 might be earache or toothache. I brought P124 back to
20 MAH and asked for a dentist to look at him. It took a 15:10
21 few days for MAH to get a dentist to see P124. It
22 turned out that he had an abscess on his wisdom tooth,
23 which must have been excruciating as the dentist had to
24 drain it and then maintain a dressing for a couple of
25 months. 15:10

26
27 In January 2019 I took P124 to the School of Dentistry
28 at the Royal Victoria Hospital to get the tooth out.
29 He needed to be anaesthetised. They had great

1 difficulty in waking him up after the anaesthesia.
2 P124 had been diagnosed with sleep apnea in 2012.
3 However MAH failed to disclose this prior to the School
4 of Dentistry prior to the surgical extraction and
5 anaesthesia.

15:11

6
7 There were issues with the administration of P124's
8 medication. On occasion, staff would hand P124 nine
9 tablets in one go to swallow without water. This is
10 despite the speech and language therapy team
11 identifying some years ago that P124 is at risk of
12 choking.

15:11

13
14 P124's father and I were allowed into P124's room when
15 he was in Erne. At times we found that his bed had
16 been made but there was a strong smell of urine. I
17 checked the bed and it was soaking. This had been left
18 for him to get back into that evening. There were also
19 times when we collected P124, he would have human
20 faeces on him.

15:11

21
22 One night when I was putting P124 to bed, he tried to
23 kiss me passionately and inappropriately. He told me
24 that H159 does that to him. H159 was a nurse in MAH at
25 this time. I did not report this at the time. I felt
26 like I have never been heard and my concerns were
27 always ignored.

15:12

28
29 There were failures to follow speech and language

1 therapy team requirements. For example, P124's food
2 should be chopped up into small pieces to reduce the
3 risk of choking. There have been failures to cut up
4 P124's food. On one occasion I attended a visit with
5 P124 at dinner time and arrived just as his dinner was 15:12
6 left out for him. The staff member just left the tray
7 of food with P124 and me. This food had not been cut
8 up and was not appropriate for him. I took a picture
9 of the plate of food and I showed this to H223. H223
10 apologised and advised it would not happen again, yet 15:12
11 it continued to happen.

12
13 P124 requires constant supervision. On occasion when I
14 would visit P124, I would find that he had been left
15 alone in his room with the door locked. When 15:13
16 challenged, staff would report that they had to go to
17 the toilet. This happened a few times.

18
19 There were also recommendations for P124 to lose weight
20 due to his sleep apnea. I do not know what, if 15:13
21 anything, was ever done about this.

22
23 I have always managed P124's money. I would have given
24 money every month for P124 to the ward in MAH. I did
25 receive receipts for expenditure for P124 when he was 15:13
26 in Erne Ward. However, before then, I never would have
27 received such receipts. The ward would have informed
28 me if P124's money was running low. Prior to Erne
29 Ward, I recall times when I would have questioned where

1 P124's money was going and how he was spending so much
2 money in such a brief period. I was told P124 was
3 spending his money on taxis to go to bowling or a
4 shopping trip because the MAH bus was hardly ever
5 available to patients.

15:14

6
7 Some of P124's property was also lost or stolen while
8 he was in MAH. For example, P14's golf clubs,
9 Wellington boots and window clearing gear all went
10 missing while he was in MAH. Even soil that we had 15:14
11 bought for P124 for a garden area went missing. On
12 several occasions, P124's phone chargers went missing
13 and we had to continuously buy new chargers. I put
14 P124's name on one of these chargers. Staff apologised
15 to me and advised they had to borrow the charger. They 15:14
16 never asked P124's permission. This was his, and they
17 should ask for permission.

18
19 Clothes also went missing. P124 was seen wearing
20 children's clothes and other people's clothes. I then 15:14
21 had to start doing P124's washing. I remember staff
22 continuously putting dirty pyjamas that had been soiled
23 with urine into the fresh bag of clothing that I had
24 just washed. I had to throw out a lot of his clothes
25 because the stench never went away. I raised this on 15:15
26 many occasions and advised staff to keep the dirty and
27 clean clothes separate but this was ignored.

28
29 I also believe that P124 had been overmedicated in MAH.

1 P124 was like a drunk man because he was so heavily
2 sedated when I visited him. At times he could hardly
3 walk and would barely be able to remember who I was.
4 At one time P124 had a cough that went on for weeks. I
5 brought him to the Lagan Valley Hospital and asked the 15:15
6 hospital if the cough could be due to the medication
7 that P124 was on. The hospital advised that this could
8 be the cause of the consistent cough. As a result, MAH
9 reduced the medication and P124's cough subsequently
10 improved. The hospital doctor also asked what 15:15
11 medication P124 was on. He asked whether P124 was on
12 any Omeprazole to protect his stomach from all the
13 other medication. P124 was not on this medication and
14 so the doctor prescribed it. He has been on this
15 medication ever since. I believe he should have been 15:16
16 prescribed this long before whilst in MAH. P124 is on
17 four different laxatives to counteract the Clozapine.

18
19 I'm aware that P124 was regularly put into the
20 seclusion room. I believe that this started soon after 15:16
21 P124's last admission to MAH in 2007. Every day when I
22 phoned MAH, I would be told when P124 was in the
23 seclusion room. On one occasion P124 was in seclusion
24 and in a state. A nurse let me go in to see if I could
25 calm P124 down. This was in or about 2009 or 2010. 15:16
26 The room that P124 was in was not padded; there was
27 just a bed and P124 was there by himself. A member of
28 staff told me that he was being unsettled and
29 aggressive and he had to be secluded from the rest of

1 the patients. In my experience, this room was used to
2 manage P124 and not as a last resort. I have never
3 been provided with the seclusion room policy or had it
4 described to me. I felt that P124 was put into
5 seclusion far too often.

15:17

6
7 I would ring PICU to get an update on P124, and quite
8 regularly I would be told that P124 was in seclusion.
9 I would have contacted the ward two or three times a
10 day. I would feel upset each time because I knew how
11 distressed P124 would have been due to being put in
12 seclusion. P14 told me that he hated the seclusion
13 room. He does not like to be on his own, and this
14 would have been a terrifying experience for him as he
15 would not have understood as to why he kept being put
16 into the room. It was not at all exceptional for staff
17 to use seclusion. On one occasion, P124 role played
18 that he had been pushed into the seclusion room. Staff
19 would have told P124 that he was going into the
20 seclusion room because he was bad. I believe that
21 staff used seclusion as a means of punishing P124.

15:17

15:17

15:17

22
23 P124 had an incident that led to some discussion with
24 his doctor on 7th August 2022. When the consequences
25 of his behaviour were discussed with P124, he had
26 misunderstood and thought he would be sent to the
27 seclusion room in Muckamore. He called this the 'green
28 room.' He became very distressed and anxious. He kept
29 saying that he could not go back there. I asked P124

15:18

1 about this room, and he confirmed that there was no
2 chair, no bed, and no toilet. I was shocked at how
3 vivid this was for P124 and how anxious he became. I
4 believe that this reveals the depth of the damage done
5 to P124 from his time in MAH.

15:18

6
7 On occasion, staff at MAH would have deprived P124 of
8 coming home or a phone call and threatened this to
9 either punish P124 or to get him to behave. Staff
10 would have deprived 124 of outings such as going
11 shopping. They would have told P124 that he was not
12 allowed to go shopping because he had been bad earlier.
13 The only caused P124 to be more aggressive. P124 lived
14 for coming home and he used to get anxious about
15 knowing exactly when I would be coming to collect him.
16 Family is everything to P124.

15:18

15:19

17
18 I was approached in March 2020 about how Covid-19 was
19 going to impact on P124 and visits. It was suggested
20 that our family might take P124 home. We decided this
21 would be for the best. This was supposed to be a
22 short-term arrangement only. P124 came home on 23rd
23 March 2020 and has been here ever since. No long-term
24 care plan has been put in place. I have not actually
25 seen his care plan.

15:19

15:19

26
27 P124 initially started to attend at a day care for one
28 day a week. This is now up to four days a week from
29 Monday to Thursday. P124's father and I are now

1 effectively providing P124 2:1 care in the home without
2 adequate support. P124 loves his day care and so we
3 want to secure a residential placement for him that is
4 close enough to the town that he is in.

5
6 MAH have now closed Erne Ward which was the
7 resettlement ward. We have been told that there is now
8 no bed for P124 at MAH, although a return for MAH would
9 be our last resort. We want P124 to be settled in the
10 community. MAH have agreed not to formally discharge
11 P124 as a patient until such time as a proper placement
12 in the community is secured.

13
14 P124 had Covid-19 in February 2022 and was quite sick.
15 I contacted H223 to update him. The pharmacist had to
16 contact H223 to advise of the impact of his medicine.
17 P124 needed a blood test done urgently due to a concern
18 as to the impact of being on Clozapine and having
19 Covid-19 at the same time regarding risk of infection.
20 H223 apologised and advised if it were not for the
21 pharmacy that he would not have known that a blood test
22 was needed. The blood test revealed that P124's white
23 blood cells were low and he was placed on amber alert.
24 H223 advised that he rang around the out-of-hours to
25 make them aware of the situation in case P124 needed a
26 bed. P124 Clozapine had to be reduced immediately by
27 half.

28
29 I had to issue judicial review proceedings on behalf of

1 P124 as of 30th May 2022 regarding his delayed
2 discharge and ongoing failure by BHSCCT to meet the
3 applicant's needs and make necessary arrangements for
4 his care in the community."

5
6 Over the page, then, the witness provides a declaration
7 of truth and the statement is signed and dated.

8 CHAIRPERSON: All right. Well again, thank you very
9 much to Tracey, who I think is watching, for that
10 statement. Thank you.

11
12 So, who is dealing with the next?

13 MS. BRIGGS: I'm dealing with the next statement which
14 is P126's mother. We can call her Edith. I am just
15 going to check with the secretary to the Inquiry that
16 everything is in place.

17
18 We are in a position to read that statement now, Chair.
19 I'm not sure if a short break is desired.

20 CHAIRPERSON: Are you all right to continue or would
21 you like a short break?

22 MS. BRIGGS: I'm fine. Thank you, Chair.

23
24 The statement reference is STN-150-1. It is the
25 statement of P126's mother and, as I say, she will be
26 called. It is in relation to P126, who has passed
27 away. He passed away in 2017. I'm going to call him
28 by his first name, David.

1 There is one thing I want to flag in relation to this
2 statement before I start to read it. The Inquiry
3 understands that the witness has informed the
4 statement-taking team at Cleaver Fulton Rankin that she
5 has come across a report in respect of her son that may 15:23
6 assist the Inquiry. That document is, we understand
7 it, being obtained and it may be that it will have to
8 be exhibited to a further short statement, but the
9 counsel team take the view that there is no reason why
10 this statement can't be read in today. 15:23

11 CHAIRPERSON: That's fine. Is she online? No. Okay.

12 MS. BRIGGS: The Court will keep Core Participants
13 updated in respect of that further statement, if it is
14 obtained.

15 CHAIRPERSON: Okay, that's fine. Thank you. She's not 15:23
16 online but obviously she's aware that this is
17 happening. Okay.

18 MS. BRIGGS: Edith then writes:

19
20 "My connection with MAH is that my son, David, was a 15:23
21 patient at MAH from around 1969 or 1970 to around 2015.
22 The relevant time period that I can speak about is
23 between 1969 or 1970 and 2015.

24
25 My family is from" and the city is named and redacted. 15:23
26 "I trained as an orderly in the Royal Victoria
27 Hospital, Belfast. I completed nursing training at" a
28 hospital in another city. "I married David's father
29 and he and I two children, David" whose date of birth

1 is a date in 1964, and David's brother is, and his date
2 of birth is given, and the year is 1967.

3
4 "I separated from David's father and I obtained a
5 divorce. I subsequently met and married David's
6 stepfather. With him, I had a third child". That
7 should say David's half-brother who was born in 1971.

15:24

8
9 "David was born at the Jubilee Maternity Hospital,
10 Belfast. I recall that the doctors missed a few things
11 during my labour with David. I do not recall all their
12 names now. My waters broke and I was left in labour
13 for too long. I recall being told this. I recall one
14 of the doctors, she did not listen to me when I was
15 giving birth but she did end up listening to me after
16 that. She ended up being supportive and giving me
17 lifts home. When I was having my other two sons, I
18 felt that the care was much better. I decided not to
19 have more children after having David's half-brother as
20 when I was expecting him, I had over five months' bed
21 rest.

15:24

15:25

22
23 When David was born, he was a happy child but he was
24 sickly. We lived in" and the place is named and
25 redacted. "The valves of his heart did not close at
26 birth and I believe this was because of a lack of
27 oxygen. I noticed David reacted to light but even as a
28 baby I thought there was something wrong with his
29 eyesight. I recognised this when David was small and I

15:25

1 took him to see our GP and various specialists but they
2 did not listen to me.

3
4 I recall one occasion when David was around seven
5 months old when he was being examined by the eye 15:25
6 specialist. I said that I thought that David had a
7 sight difficulty. He initially dismissed my comment.
8 I told him to take David to the window. When he did
9 this, the eye specialist realised, by David's reaction,
10 that he wasn't totally blind. David was diagnosed with 15:26
11 glaucoma.

12
13 David was diagnosed with Rubinstein-Taybi Syndrome when
14 he was little. This wasn't diagnosed immediately. I
15 think we all realised the extent of David's ill-health 15:26
16 by the time he was around three.

17
18 Despite his challenges, David was a happy child. He
19 loved music, particularly classical music. David had a
20 little musical poodle toy and this is how David would 15:26
21 have put himself to sleep. David had a little bird
22 that he loved. David would go to the bird's cage and
23 make noises up to the bird and the bird would reply.

24
25 David was a well-liked child with a happy demeanour. 15:26
26 For example, he was so popular with our local ice-cream
27 man that he would stop his van outside our home and
28 wait until David's father and I came out to get David
29 an ice-cream. David's hearing was so good that he

1 would hear the ice-cream van from far away. David used
2 to go to the window and clap when he heard the
3 ice-cream man.
4

5 David would know when I was getting ready to leave the 15:27
6 house and go to my mother's. He would communicate with
7 me by making noises and clapping. When David was
8 around five years old, the education authority came to
9 our home and said that I had to send David to school.
10 I had no support and I wasn't sure how they were going 15:27
11 to cope with David, and how he would like it.
12

13 For a while David was in a home for a number of months.
14 This was a place for children with learning
15 disabilities. He was there for a while, but then we 15:27
16 returned to our home city. David was discharged and
17 sent back to our home city as the home did not have the
18 facilities to deal with David. When back in our home
19 city, David spent a short time in the children's
20 hospital in Belfast. I do not recall the dates. I 15:27
21 recall the staff there not listening to me. I recall
22 one nurse, whose name I do not recall, complaining to
23 me about the mithering mothers. I found their attitude
24 dismissive.
25

26 While David was in Ava's Children's Hospital in
27 Belfast, he was examined by the eye specialist. I
28 recall that he told me that he would normally have
29 treated David with a procedure which would have fixed

1 his eyes permanently by installing drains. He told me
2 he could not do this to David due to David's heart
3 condition as the operation would be too dangerous.
4 David was treated with needling to the eyes. He
5 developed glaucoma and by the time he was five and
6 being admitted to MAH, he was blind.

15:28

7
8 I separated from David's father and divorced him. We
9 did not have a happy marriage."

10
11 There's personal details; I will not read that.

15:28

12
13 "I recall visiting David when he was admitted to MAH
14 and I remember him at the end of my visit crying when I
15 returned him to MAH staff. David did not really have
16 any speech so he could not really communicate with me
17 in a normal way. I could tell from David's mannerisms
18 what he wanted. I think that obviously a mother knows
19 their child, but an MAH staff member would be able to
20 tell what David needed by watching him and paying
21 attention to him.

15:28

15:29

22
23 I recall one incident when David was around six or
24 seven years old that I was told that David had a broken
25 arm. I do not understand how a child of that age gets
26 a broken arm and I was not happy about it. I
27 complained to MAH at the time but I do not think I got
28 a good response. I recall that I was told that David
29 was moving from one ward to another but I do not recall

15:29

1 further details or who I spoke to in connection with
2 the complaint.

3
4 In 1971 I took my children and moved to another city.
5 I was tired of bullets ricochetting off our home. 15:29
6 David's half-brother was six weeks old at the time. I
7 would visit as often as I could. I would use my
8 holidays to go to see David and, during the summer
9 holidays, we would go over as a family so David got to
10 spend time with his brothers. I would visit three or 15:29
11 four times per year and stay with my husband's family
12 or my own family.

13
14 We tried to move back at one point in 1972 or 1973 but
15 my husband got a job with a company in Denmark and had 15:30
16 to move there. As a result, I eventually moved to
17 another city. I didn't want to be so far away from
18 David or my family.

19
20 David's father was murdered in 1976. I do not believe 15:30
21 that any of his family visited MAH.

22
23 I used to send care packages to David and worked so
24 hard to ensure that he wanted for nothing. I would
25 sent David things like clothes and CDs. He continued 15:30
26 to love music as he got older.

27
28 I would normally ring MAH and let them know that I was
29 coming. I became a little suspicious about the care

1 that David was receiving so I started showing up
2 unannounced. David had always been well turned out
3 when I visited but when I visited without calling in
4 advance, I found that it would take MAH staff over 20
5 minutes to bring him to me or let me see him. I
6 believe that this is because they had to get him ready
7 as he was in a poor state of dress and/or cleanliness.

15:30

8
9 I recall on one visit, always I am not sure of the
10 date, that David was uncomfortable. When I examined
11 him, the skin of his back was broken. It was red in
12 places, had scabs, and I felt that I could see bone
13 through wounds. I complained to MAH staff and I was
14 told that David did this to himself by taking off his
15 top and scratching his back against door frames. I was
16 not happy with this response. I do not recall who was
17 involved in this incident. I recall asking staff to
18 change his clothing to something more suitable so that
19 this injury could be avoided.

15:31

15:31

20
21 I recall another visit, although I am not sure when
22 this was, that David was brought to me and his nose had
23 been bleeding. He had blood on his clothes. I was
24 angry about this and complained to staff and asked that
25 he was tidied up and given fresh clothes. I do not
26 recall who dealt with my complaint.

15:31

15:31

27
28 David did not have good mobility due to his blindness.
29 He would feel his way around. David had no issues with

1 his hearing and would have followed television
2 programmes. I recall watching comedies with David and
3 sometimes he would get the joke and laugh before I got
4 it.

5
6 I recall an attempted resettlement of David. I did not
7 like the way that it was handling or how David or I
8 were treated. I am not sure when the resettlement was,
9 but it was to a facility in", and the location is
10 used. "I do not recall the name of the place and I
11 have destroyed most of my papers relating to David.

12
13 I recall that David was sleeping during the day and
14 that he did not settle there. I do not think that
15 David should have been resettled without me being happy
16 about it and agreeing to it. I made sure to stress
17 when resettlement was suggested by MAH that they
18 maintained a place for David there. The resettlement
19 ended and David was brought back to MAH. I do not
20 recall the dates.

21
22 David was returned to MAH. I do not recall the names
23 of the wards that David was on but I did call them
24 every night for updates on his care. I recall David
25 being on a number of wards including Ennis Ward. I
26 recall receiving telephone calls from MAH staff about
27 David and them telling me about incidents or injuries.
28 I do not recall dates or who I spoke to but I ended up
29 being very concerned about the standard of care. I

1 complained to MAH staff but was told that the injuries
2 were caused by other patients. I did not feel this was
3 acceptable so I contacted the police. I attach a copy
4 of PSNI records as Appendix 1."

15:33

6 Panel, I don't propose to go to that Appendix 1. It's
7 actually exhibited as Exhibit 1, and it details a
8 complaint made in 2021 to the PSNI. As I say, Panel,
9 you have that and I don't intend to go there for
10 today's purposes.

15:33

11 CHAIRPERSON: Okay, thank you.

12 MS. BRIGGS: "I recall during my visits to MAH that it
13 was generally clean although not as clean as other
14 hospitals.

15:33

16 I recall MAH suggesting a resettlement for David as I
17 believe that they wanted to close MAH. I didn't agree
18 to this because I did not think it was right for David.
19 I cannot recall where David was going to be moved to.
20 I recall that MAH threatened me with court action if I
21 did not agree.

15:34

23 I didn't get to know any of the doctors really but I
24 understand that David had a number of doctors,
25 including a psychiatrist. The only doctor I recall was
26 the eye specialist from the Belfast City Hospital. I
27 agreed to David participating in a medical trial about
28 Rubinstein-Taybi Syndrome that he was running. I
29 recall that I was told that it wouldn't help David but

15:34

1 it could help people like him in the future. I don't
2 recall details of the trial.

3
4 I recall that Ennis Ward was the last ward David was
5 on. David was resettled from MAH in about 2015 and 15:34
6 moved to a nursing facility", and the location is
7 there. "I do not recall the name of the place.

8
9 When David was moved, the care was much better. When
10 David was sick, the people there would contact me. 15:35
11 SW14 was David's social worker.

12
13 I made sure that David's surroundings were as safe and
14 pleasant for him as I could make them. He had storage
15 units and furniture that was specially built for him so 15:35
16 that it could not be pulled down when he using it to
17 walk around. He had a beanbag that he loved. David
18 also had a stereo so he could play his CDs.

19
20 David's health deteriorated in November 2016 and they 15:35
21 sent for me. I went over and they took very good care
22 of me and David. I recall the staff visiting David and
23 sitting with him, even when they weren't working.
24 David made a recovery but eventually passed away on
25 26th February 2017. It was a very difficult few weeks 15:35
26 as David's stepfather died the previous week and my
27 sister died the following week.

28
29 When David passed away, I told the staff that they

1 could keep the furniture so that it could help someone
2 else. The staff went to David's funeral. Very kindly,
3 the staff also give me a little angel on the day of the
4 funeral and afterwards they sent me a memory box.

15:36

6 I feel that if people had been listening to me about
7 MAH from the start, this could have been avoided. The
8 whole time that P126 was in MAH, I thought he was safe
9 but now I don't think that he was. I do not know what
10 nightmare he was living through and he was unable to
11 tell me. I feel that doctors need to start listening
12 to people. They are not gods. These people need to be
13 held accountable.

15:36

15 David wanted for no physical possessions. I sent him
16 all that I could and all that he needed. The only
17 thing that David wanted for was a life. When he was at
18 MAH, he did not have one.

15:36

20 I feel very strongly that medical professionals and
21 nursing professionals should be properly scrutinised
22 and vetted to ensure that they are fit to care for
23 people.

15:36

25 I feel that nobody connected to MAH seems to learn from
26 their mistakes and feel, very strongly, that they
27 should listen to the parents more. Parents' wishes and
28 feelings should not be ignored.

15:36

1 I feel that there should be openness and transparency
2 about what happened at MAH. While my son David is dead
3 and this statement cannot help him, I want to be his
4 voice in this process and make sure that others receive
5 better treatment."

15:37

6
7 The statement is then signed over the page at page 8
8 and dated by the witness, and then the exhibits
9 thereafter follow, the first exhibit being the PSNI
10 records which I have already referenced to you, Chair,
11 and photographs, which are redacted.

15:37

12 CHAIRPERSON: In relation to that, it's worth noting
13 that each of the reports, in fact, seem to relate to a
14 patient assault as opposed to anything else.

15 MS. BRIGGS: Yes.

15:37

16 CHAIRPERSON: I know Edith isn't watching but she may
17 one day read this the transcript so I just want to make
18 sure that she too is thanked for that statement.

19 MS. BRIGGS: Thank you, Chair.

15:37

20
21 The next statement that is on the running order is the
22 statement of P127. Just give me a moment, I am going
23 to check the position with the secretary. I am
24 informed that P127 won't be attending remotely or in
25 person today but I am ready to read that statement,
26 subject to the Panel. I know that after this one,
27 Ms. Tang has one more as well.

15:38

28 CHAIRPERSON: Are you up to carrying on? Just tell me.
29 If you need a break, we can have a break.

1 MS. BRIGGS: I am. This is a short statement, Chair.

2 CHAIRPERSON: All right. Is the witness zooming in?

3 MS. BRIGGS: No. The reference STN1-145-1. It is the
4 statement of P127 and it is dated 6th September 2023.
5 It reads as follows:

15:38

6
7 "My connection with MAH is that I was a patient at the
8 Hospital. The relevant time period I can speak about
9 is between 2016 and 2017. I cannot recall the exact
10 dates that I was admitted and discharged from MAH. I
11 was born on", the date is redacted, "and I am 25 years
12 old. I currently live with my aunt. I have a younger
13 sister who is 21 years old, and she lives with me and
14 my aunt as well.

15:39

15
16 I was diagnosed with Attention Deficit Hyperactivity
17 Disorder (ADHD) when I was around 14 or 15 years old.
18 I was diagnosed whilst at the Iveagh Centre in Belfast,
19 which is a hospital inpatient facility for young people
20 with a learning disability and mental health problems.
21 I was described medication for my ADHD at the Iveagh
22 Centre but I cannot recall the name of the medication.
23 I was describe Diazepam around this time as well. I
24 was in the Iveagh Centre because I was self-harming.
25 When I turned 18 years old, I went to MAH.

15:39

15:39

15:39

26
27 I wish to give information to the Muckamore Abbey
28 Hospital Inquiry because of the way I was treated in
29 MAH. I would describe MAH as a jail. My room was

1 locked all the time. When I was first admitted to MAH
2 around 2016, I was on the ICU ward. When I was on the
3 ICU ward, there was a male patient who was always
4 feeling my leg. I told him not to, and I complained to
5 the staff. I cannot recall the name of staff members I 15:40
6 complained to. It was a mixed ward of male and female
7 patients. This happened for about six weeks and
8 eventually the staff moved me to another ward.

9
10 In the ICU ward, there was a room that the staff put me 15:40
11 into. I was put in alone and the door was locked. The
12 staff put you in there so that they did not have to do
13 anything. I remember that a female patient hit me and
14 I hit her back. I cannot remember the name of the
15 patient. I was put in the room as punishment instead 15:40
16 of her. I was put in there eight or nine times while I
17 was in the ICU ward. There were no windows or
18 furniture in the room. There was a door with a small
19 window. There was nothing to sit on and it was not
20 comfortable. There was no toilet. I knocked the door 15:41
21 to go to the toilet but the staff did not listen and
22 just ignored me. The staff did not let me out and I
23 had to wait until they decided to let me out. It was a
24 long time, perhaps half a day.

25 15:41
26 I do not remember any of the staff's names on the ICU
27 ward but they were mostly male staff. I would act
28 stupid but I was listening to their conversations and
29 taking it all in. They said bad things about the

1 patients and I said to myself 'Why they are working
2 here if they think like that'. I cannot remember the
3 specific things that the staff were saying.
4

5 I was then moved to Donegore Ward. I had my own room 15:41
6 there but there was not much in it. It was very bare.
7 It had a bed, a wardrobe and a locker; nothing else. I
8 did not have any of my own things there. We were not
9 allowed personal things.

10 15:41
11 I went to school and I got a taxi there every day from
12 MAH and a taxi back again to MAH. My school day was
13 from 9:00 a.m. to 3:30 a.m. I had my lunch in school
14 but I starved in MAH. I ordered the food I wanted in
15 the morning but the food that came was rarely what I 15:42
16 ordered and most of the time there was nothing brought
17 to me at all. You were supposed to eat in the dining
18 room but I did not like to be in there as there were
19 too many people. The staff were supposed to bring my
20 food to my room. I told my aunt that I was not being 15:42
21 given food and she complained to the staff. I do not
22 know who she complained to but nothing happened. I
23 would call my aunt on my mobile phone to order me a
24 Chinese takeaway if my dinner did not come. The staff
25 had to give me the Chinese food as if they did not, my 15:42
26 aunt would come up to MAH. Sometimes I had no
27 breakfast and no lunch and I just had to wait until
28 dinner to eat.
29

1 I had visits from my aunt, my dad and sometimes my
2 cousin and his wife. They would bring me treats and
3 sweets. I remember that they were told by staff that
4 they could not take me out of the grounds of MAH but my
5 cousin told them he was an barrister. My cousin
6 complained to staff and they allowed him to take me
7 out. Most of my visits were at the Cosy Corner café in
8 the grounds of MAH. I would go to school and my family
9 would usually visit a couple of times a week after
10 school.

15:43

15:43

11
12 I was not supposed to have a mobile phone. The staff
13 said I was not allowed a mobile phone in MAH, but my
14 aunt gave it to me so that I could call her and I hid
15 it under my pillow in my room. I had the phone for
16 around four months and when I went to school, I hid it
17 in my bag.

15:43

18
19 I cannot remember any of the staff's names on Donegore
20 Ward but they were mainly women. None of the staff
21 were nice to me or the other patients. They would be
22 all nicey-nicey when my family or other people came to
23 visit but when the parents went home, they would were
24 not nice. The staff treated us like rubbish. They did
25 not speak to me in a nice way. I cannot remember
26 anything in particular that they said as it was too
27 long ago and I try not to remember it.

15:43

28
29 The staff would pull you about and grab you, and they

1 did not treat me nicely. It was mainly two female
2 staff that did it and it was always in my room, not in
3 the ward where people could see.
4

5 I told my aunt about how the staff treated me and the 15:44
6 other patients. Sometimes I would ring my aunt and
7 leave the phone on so that she could hear how the staff
8 were treating me and speaking to me. My aunt heard
9 some of the things they said. They would slabber at
10 me. By that, I mean not speaking in a nice way to me. 15:44
11 I cannot remember any of the things the staff would
12 say.
13

14 There was always fighting on Donegore Ward. I was hit
15 by other female patients. Fighting always happened in 15:44
16 the hall or the living room. The staff were there and
17 they saw it but they did not stop it. I remember
18 another patient called P131 hitting me and the staff
19 did not tell her off. They were always too busy on
20 their phones and they never did anything. I complained 15:44
21 all the time about it and I told my aunt. I cannot
22 remember who I complained to. My aunt would phone the
23 staff on the ward. I do not know who she spoke to. I
24 had bruises on my arms and my back. I lost count of
25 how many times it happened. They pulled my hair out 15:45
26 too. I took photos on my phone of the bruises I had
27 but I do not have the photos anymore. It was always
28 during the day and not at night. I do not remember any
29 dates, staff names or other patients' names as it was

1 too long ago.

2
3 My aunt told me that there was a meeting to talk about
4 me. I do not know the date of the meeting. My aunt
5 told me the meeting took place across the road from the 15:45
6 Mater Hospital in Belfast. She wanted to bring my
7 cousin, who is a barrister, but they said no. He
8 turned up anyway and he attended the meeting. I do not
9 know who else was there but I think there were doctors
10 and social workers. My aunt told me that the staff 15:45
11 said it was not suitable or safe for me to go home but
12 my family wanted me to go home because of the way I was
13 being treated. A staff member on the Donegore Ward
14 told me that there was a plan to send me to England. I
15 cannot recall her name or the date of the conversation. 15:45
16 However, it was a female member of staff. I think they
17 wanted me away from my family so that I would not tell
18 them about the things the staff were doing to me. I
19 told my aunt that I did not want to go to England. My
20 aunt told me she notified them at the meeting that I 15:46
21 did not want to go to England. She insisted that she
22 would fight any decision to send me there. I wanted to
23 go home. I do not know what else was said at the
24 meeting.

25
26 The people at the meeting agreed to allow me to go home
27 to my aunt's house on a two-day trial. However, I
28 never went back to MAH again. I had to go back for a
29 meeting a couple of weeks later. I told them that I

1 was not going back again so they discharged me. I was
2 so happy, I ran out of the place.

3
4 I did not like MAH. I pity the poor patients who are
5 still there. I hear it is closing down soon. I think 15:46
6 that it should have been shut down years ago because of
7 the way the staff treated the patients. I still live
8 with my aunt, my sister, and my four dogs."

9
10 Over the page, then, the statement is signed and dated. 15:46
11 CHAIRPERSON: Thanks to Patient 127.

12
13 MS. BRIGGS: Thank you. I think Ms. Tang is reading
14 the final statement this afternoon.

15 MS. TANG: The secretary has confirmed that the witness 15:47
16 is not watching remotely, so I propose we go ahead.

17
18 The final statement is that of P129's brother. The
19 internal page reference is STN-152-1, and there are no
20 exhibits to the statement. The statement is dated 15:47
21 8th September 2023.

22
23 "I, P129's, brother, make the following statement for
24 the purpose of the Muckamore Abbey Hospital Inquiry.
25 There are no documents produced with my statement." 15:48
26

27 The witness gives the name of a registered intermediary
28 who was in attendance with them when they were making
29 the statement.

1
2 "My connection with MAH is that I am a relative of a
3 patient who was at MAH. My brother, P129, was a
4 patient at MAH between 1995 and 2004. The relevant
5 time period that I can speak about is between 1995 and 15:48
6 2004.

7
8 I wish to give information to the MAH Inquiry regarding
9 my brother, P129, and the treatment he received at MAH.

10 15:48
11 There Were six children in our family. P129's sister
12 is the eldest and P129's sister is the youngest. There
13 are two years between us all."

14
15 The witness then lists the members of the family. A 15:48
16 sister born in 1980; P129 --

17 CHAIRPERSON: I don't think we need to go through all
18 that.

19 MS. TANG: Thank you.

20 15:49
21 Moving on to paragraph 5, then:

22
23 "I was very close to my brother, P129, when we were
24 growing up and I am still today. I left school at
25 around 12 years of age and started doing this and that. 15:49
26 I would scrapping with my dad and my brothers, P129",
27 and the other brother

28
29 "My brother was a normal child. I was not aware of any

1 issues with him. However, I thought he was a bit of a
2 wild child. He had no diagnosis of anything when he
3 was younger than I am aware of.

4
5 P129 had a very difficult time in his teenage years. 15:49
6 He was sexually abused by a neighbour when he was 12 or
7 13 years old. P129 would have been the sort of child
8 who would do anything for you. For example, he would
9 ask you if you wanted anything from the shop. He went
10 to the shop for a neighbour. I think the abuse went on 15:49
11 for a while. He became very hard to handle after that.
12 By that I mean that he ran away a lot. I do not think
13 he got counselling or anything like that and he could
14 not cope with what happened to him. I also found these
15 events very difficult, both at the time and since, as I 15:50
16 was so close to P129. I was diagnosed with
17 Post-Traumatic Stress Disorder as an adult due to these
18 family experiences and what happened to P129.

19
20 Initially, P129 was admitted to MAH in or around 1995 15:50
21 when he was approximately 13 years old. He went for
22 weekends at the beginning, then for the week and then
23 for a month. I am not sure about why P129 was admitted
24 but I was told, and understand, that it was for respite
25 care. I remember at the time thinking that he was 15:50
26 slowly disappearing from our family. I think that went
27 on for about six months or so. My mother dealt with
28 P129's care and the dealings with MAH, so I am not
29 aware of the specific dates, staff members' names or

1 the wards that P129 was on at this time. My mother
2 kept a lot of this information from myself and my
3 siblings as we were still young at the time. During
4 this time, I visited P129 at MAH.

15:51

6 Due to these incidents taking place a long time ago, I
7 am not able to remember specific dates of incidents or
8 specific names of staff members. I was a teenager when
9 P129 was admitted to MAH but I have included as much
10 detail as I am able to remember during this process.

15:51

12 P129 was sectioned into MAH on a full-time basis after
13 approximately six months, or perhaps a year, of respite
14 care. I am not sure exactly where, but it was because
15 there were allegations that P129 did something wrong.
16 I remember it may have been allegations of fighting
17 with other patients or staff. However, I am not sure.
18 I cannot remember the name of the ward that P129 was
19 on. I only ever visited P129 that same ward for the
20 whole time that he was at MAH. You go into the main
21 entrance and take a left to get to the ward. It was in
22 the new part of MAH. I do not know if he was ever on
23 different wards while he was at MAH.

15:51

15:51

24
25 My mother is 129's next of kin and, when we were
26 younger, she told us that you could only visit P129
27 three times a year. I found out a few years later that
28 this was a load of lies. I think she could not cope
29 with seeing P129 in there. My mother and all of the

15:52

1 children went to visit P129. I do not remember our dad
2 going to visit.

3
4 After a few years, we began to visit P129 every other
5 weekend. I normally visited with other family members, 15:52
6 but one time I visited on my own as I was working up
7 that way. My mother would usually have called in
8 advance to tell them we were coming. This time I
9 visited by myself, I just arrived without phoning
10 ahead. Sometimes my mother was told when she phoned 15:52
11 that we could not visit as it was not safe. I was not
12 told the details of why it was not safe. A
13 receptionist would normally greet you at the door. You
14 could just walk in and the door was not locked. Our
15 visits were unusually in the visitors' room, a small 15:53
16 room off reception on the left-hand side. It was just
17 us and P129 in the room, but other patients would have
18 banged on the door and screamed during our visits.
19 Sometimes we took P129 out on the grounds of MAH to the
20 café. Sometimes we had our visits in the yard which 15:53
21 was also in the grounds.

22
23 One time, I cannot remember the date, I visited P129
24 unexpectedly as I was working in the area, and I did
25 not ring ahead. There was no one at reception and I 15:53
26 was able to walk right in. There were double doors to
27 the left which led to the ward and the rooms. I looked
28 right, down a long corridor and into the hall and I
29 could see P129 sitting on a chair. When I got closer

1 and into the hall, I could see P129 was sitting on a
2 chair facing the wall away from me. There were two
3 male members of staff standing, one on each side of the
4 hall. They were laughing and making fun of P129. P129
5 was silent and facing the wall. I cannot what they 15:54
6 were saying but I shouted for them to get whoever was
7 in charge. One staff member left and one staff member
8 stood outside the door. P129 turned around and he
9 looked sad, lost and scared. He looked like a shell of
10 himself. I could hear music from the next room off to 15:54
11 the left. P129 said that the staff members had locked
12 the door and did not allow him to go through to play
13 pool at the pool table. H530 then arrived. I knew
14 Dr. H530 as someone who looked after P129, and I asked
15 him what was happening and why the staff would not open 15:54
16 the door. H530 said that there was a disco on but P129
17 did not want to go. P129 said he was not allowed into
18 the room to play pool. P129 told me not to ask for the
19 door to be opened but I asked H530 anyway, and he did
20 so. P129 and I played pool and ate a sandwich 15:55
21 together.

22
23 When P19 went into MAH, I do not remember him being on
24 any medication. At first he was normal but, over time,
25 he became more and more doped up. By that I mean that 15:55
26 he seemed to be on a lot of medication and he was very
27 drowsy. For example, P129 would ring me up from the
28 landline. You could not understand what he was saying
29 times, he had slurred speech. He usually rang before

1 he went to bed and he seemed to get his medication at
2 that time too. We had to tell him to call us before he
3 got his medication as we could not understand him after
4 he had taken it.

5
6 P129 rang about once a week. Sometimes he rang more
7 often when he was upset about something. When
8 something was happening to him, he would ring every
9 night, upset, crying and saying he wanted to come home.
10 It was as if there was something he wanted to tell us
11 but he could not.

12
13 P129 also told me that he was injected by the staff at
14 MAH. He said they gave him injections to sedate him.
15 I cannot remember the staff members' names or the dates
16 P129 said it happened, when he was answering back and
17 the staff held him down. It was usually a number of
18 men, as P129 was a big fella. My mother would ask the
19 staff what happened but they always said that P129 was
20 kicking off and that it was to protect themselves.
21 Sometimes when we arrived for a visit, we were told
22 that P129 was not fit to see us and we were sent away.
23 This only happened a couple of times when my mother did
24 not ring ahead. She was trying to see if P129 was
25 telling the truth about the incidents he said were
26 happening.

27
28 P129 told me that he suffered physical and mental abuse
29 at MAH. The abuse went on for the whole time that he

1 was in MAH but I do not know any specific dates. P129
2 told me that he was often placed in a padded room. He
3 was put in solitary confinement. He hated it. He
4 hated the whole place. I do not have any details of
5 the room or where it was as I never saw it. He said he 15:57
6 was placed there by the staff looking after him but I
7 do not know their names. They were always male staff.

8
9 There was one male staff member, H530, who generally
10 looked after P129. He was useless and two-faced. By 15:57
11 this, I mean my mother was taking H350's word over
12 P129's.

13
14 P129 told me that when he was in the padded room, the
15 staff would spray him down with a cold hose. I do not 15:57
16 know the names of the staff who did this or when, but
17 P129 said it happened regularly. I do not remember
18 when he told me about these incidents and I do not have
19 any further details about them.

20 15:58
21 P129 told me that he was physically assaulted by the
22 MAH staff. P129 was full of bruises and he had several
23 broken bones whilst at MAH. P129 showed me the bruises
24 on my visits but he would always check in case the
25 staff were watching. He was worried that he would be 15:58
26 caught by them, and he was scared of them. He showed
27 me bruises on the front and back of both arms, and he
28 pulled up his top to show me bruises right down the
29 side of his back. He also suffered a broken hand and a

1 broken arm but I do not know how those injuries
2 happened. When my mother complained to the staff, they
3 said that the bruises and injuries were caused by other
4 patients fighting with P129 or that P129 was kicking
5 off. When P129 said it was the staff, the staff said 15:58
6 he was talking nonsense. I do not know any of the
7 staff names or the dates of these incidents. I would
8 need to get P129's medical records from MAH. The only
9 other staff member I remember was a nurse called H531.
10 I think his wife also worked in MAH. His name might 15:59
11 have been H531 but I cannot be sure.

12
13 P129 knows of many other patients that were also abused
14 by staff at MAH. P129 told me recently, when I visited
15 him in Scotland, that he knows of 36 patients who were 15:59
16 abused by staff at MAH. P129 told me that he knows all
17 of the staff names who did it and what they did.

18
19 P129 also complained to my mother and I that the staff
20 used to do things like put salt in his tea. We did not 15:59
21 believe him at first but when we were visiting P129 at
22 one time, the staff brought us some tea. We tasted his
23 and it was full of salt.

24
25 P129 told me that the staff would take his tuck and 15:59
26 allow other patients to take his tuck from his room.
27 When I say tuck, I mean the treats that we brought for
28 him or the treats and sweets that he bought from the
29 shop in MAH. The parents were allowed some money to

1 buy things from the shop. P129 enjoyed doing this and
2 he kept the tuck in his room. P129 told me that the
3 staff took this for themselves, and they also let other
4 patients go into the room and take what they wanted.
5 P129 did not complain and neither did my mother. We 16:00
6 did not want to make things worse for P129.

7
8 P129 tried to run away several times from MAH. I do
9 not know the actual dates but it was in the first few
10 years of him going to MAH. P129 hated MAH and he tried 16:00
11 to take his own life on at least two times that I know
12 about. I do not know the dates as I cannot remember.
13 I was not told by MAH or my mother, I was told by P129.
14 If a staff member told my mother about the suicide
15 attempts, she did not share this information with me. 16:01
16 The first time, P129 tried to swallow a spoon. He was
17 found by staff. P129 told me about this when we were
18 out for a walk, and my mother was walking ahead. P129
19 should have been under watch after that. However, he
20 tried to hang himself with bedsheets another time in 16:01
21 his room. He was disturbed by staff during this
22 attempt. P129 told me about this on a visit but I
23 cannot remember the date. I do not understand why
24 someone was not watching him after the first attempt.

25 16:01
26 P129 was sent to a facility in Scotland in 2004. I was
27 very upset about this. I am disgusted that P129 was
28 allowed to be sent to Scotland. The MAH staff said
29 that P129 was trying to kill another patient with a

1 belt. I do not believe this as P129 is not a danger to
2 anyone. In any case, the patients are not allowed
3 belts in MAH. P129 was sent to Scotland around the
4 time that the allegations of abuse were coming out
5 about MAH, and I think this is why he was sent. P129
6 has evidence about the abuse of other patients as he
7 told me he witnessed it.

16:02

8
9 P129 is in a facility in Scotland. We are trying to
10 get P129 back to Northern Ireland and I am getting help
11 from his social worker, H546. H564 is based in" a
12 facility, "and also SW12, who is the social worker from
13 another facility in Armagh. I do not think that P129
14 needs to be in hospital; he is not a danger to anyone.
15 I take my children to see him. He is not even on
16 medication anymore in Scotland. He has been in
17 Scotland for 19 years and was in MAH before that from
18 1995.

16:02

16:02

19
20 It is not fair that he has been locked up all this time
21 because he was sexually abused as a child and no one
22 helped him. I am determined to get him home and I want
23 P129's voice to be heard. I do not want the staff to
24 get away with how they treated P129 and the other
25 patients at MAH."

16:03

26
27 The statement is then concluded with a declaration of
28 truth and signed and dated, and there are no exhibits
29 with the statement.

1 CHAIRPERSON: All right. Again, I want to thank
2 Patient 129's brother very much for that statement.
3

4 All right. Does that conclude the reading for today?

5 MS. TANG: Yes. My colleague, Ms. Briggs, has kindly
6 let me know that tomorrow we will be hearing from two
7 witnesses. There's a slight change to the schedule.
8 The first is P109's mother at ten o'clock, and then
9 following that P57's brother.

16:03

10 CHAIRPERSON: Yes. We've shifted the other witness,
11 P110?

16:03

12 MS. TANG: Yes, that's correct.

13 CHAIRPERSON: All right. Ten o'clock tomorrow. Thank
14 you very much, everybody, again much. We'll see you
15 all at ten o'clock.

16:04

16
17 THE INQUIRY WAS THEN ADJOURNED UNTIL THURSDAY, 21ST
18 SEPTEMBER 2023 AT 10:00 A.M.
19

20
21
22
23
24
25
26
27
28
29
16:04