MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 5TH JULY 2022 - DAY 9

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

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THE INQUIRY RESUMED, AS FOLLOWS, ON TUESDAY, 5TH JULY 2022

CHAIRMAN: Thank you very much. Just give me a minute to set up, Mr. Doran. Yes.

MR. DORAN: Good morning. I'll provide a brief introduction to today's evidence. The first witness is the brother of a former patient who is ciphered in the schedule as P3. The witness will be giving his evidence via video link. Mr. McEvoy will be dealing with his evidence.

I can confirm that the witness wishes to be referred to by his first name, Ian, and that his brother, too, will be referred to by first name, that is Stephen.

Following on from this oral evidence, two statements will be read. First, Ms. Briggs will read the statement of the sister of a former patient, P10, into evidence. Secondly, Ms. Tang will read the statement of a former patient, P6, into evidence.

This afternoon the Inquiry will hear from the sister of a former patient, P13. Ms. Kiley will be taking that witness.

CHAIRMAN: And I think that witness is coming live to the Inquiry.

MR. DORAN: It is hoped that the witness's evidence will be given in the hearing room, but that is

obviously subject to confirmation by the witness when she attends this afternoon.

CHAIRMAN: Sure. Sure. All right. Mr. McEvoy.

MR. McEVOY: Thank you, Chair.

10:03

Just before we commence formally, can I just check, Ian, you can hear me and see me okay? Can we just check the audio again, please?

IAN: Yes, that's okay.

MR. McEVOY: Okay. And you can see into the room and her me okay? 10:03

IAN: Yes, I can see you, no problem.

MR. McEVOY: Can I ask for the witness to be sworn, please.

IAN (BROTHER OF P3), HAVING BEEN SWORN, WAS EXAMINED BY MR. McEVOY AS FOLLOWS

1 Q. MR. McEVOY: Good morning, Ian. I understand that you were able to follow the introduction to proceedings this morning. Is that right? 10:03

A. Yes.

2 Q. I'll introduce myself formally. My name is Mark McEvoy. I'm one of the Inquiry junior counsel. We met briefly this morning. 10:04

A. Okay.

3 Q. You can see on your screen, hopefully, the Inquiry Panel, Mr. Kark, the Chair. To his right, Prof. Murphy, and to his left then Dr. Maxwell. Then

you can see the representative of the various Core Participants in the room, is that right?

A. Yes.

4 Q. Okay. Well, look, what I'm going to do in a moment or two is I'm going to read out the statement that you provided to the Inquiry statement-taking team. I just want to indicate to you that, as we discussed before the proceedings commenced this morning, that I'm not going to specifically identify some of the locations and names that are mentioned in your witness statement, and the reason why I'm going to do that, or avoid doing that is because we want, so far as is possible, obviously, to preserve your privacy and Stephen's privacy. But there may be an occasion, and there have been plenty so far, where there has been a slip. But I don't want you to worry about that, and the Inquiry certainly don't want you to worry about that, and if it does happen, please don't be unduly concerned. We can take measures to overcome that. All right? 10:04 10:04 10:05 10:05

A. Okay.

5 Q. When I finish reading your statement I have a few brief questions, a few matters that I wanted to ask you about, and then it may be when that questioning is finished there may be matters that the Inquiry want to ask you about. There may not be, but they may have questions of their own. All right? 10:05

A. Okay.

6 Q. So the first thing then that I wanted to take you through was the statement, as I mentioned. It is a

statement that you prepared in conjunction with the Inquiry statement team, and if we can go to the very final page of it. It is signed and dated 30th March 2022; is that right?

A. Yes. 10:05

7 Q. Okay. I'm just going to read it out now, and if at any stage you can't hear me or if there is a breakdown in the link, would you just raise your hand and then we can attempt to fix it, but hopefully everything is working all right. 10:06

A. Okay.

8 Q.

"I, Ian, make the following statement for the purpose of the Muckamore Abbey Inquiry and exhibiting any documents I will use Ian and number. So my first 10:06 document will be Ian 1.

My connection with Muckamore Abbey is that I'm a relative of a patient who was at Muckamore. My brother, Stephen, was a patient. I attach a photograph 10:06 of Stephen at Ian 1."

We'll look at the paragraph afterwards, all right, in a little bit more detail.

A. Okay.

9 Q.

"The relevant time period that I can speak about is between 16th December 1988 and the 21st October 2013.

My brother, Ian, was born on..."

You give the date then.

"He is 53 years old. Stephen..." 10:06

I beg your pardon.

"Stephen has Down Syndrome with behavioural issues and needs 24/7 care. He is limited in what he can do for 10:06 himself. He needs assistance with feeding and bathing. He used to be able to walk but he now uses a wheelchair and he sleeps on a sofa.

Stephen was initially cared for at home but moved to an 10:07 adult centre where he stayed until he was 19. He was then moved to Muckamore as they started to have some trouble with him. A doctor came to the house and assessed his needs. Stephen was very strong and could be difficult to deal with. It was recommended that he 10:07 be moved to Muckamore.

My brother was a patient at Muckamore between 16th December 1988 and 21st October 2013. He had two other placements during this time period which I have 10:07 detailed below. Doctor..." 5

- and you give the name:

"...was his doctor at Muckamore.

Stephen was initially placed in a locked ward at Muckamore. There were a lot of violent patients in this ward and a lot of shouting which really upset Stephen. He should never have been put there. It was a very old building and it was like a prison. This ward was not appropriate for Stephen's needs and it didn't feel right for him. 10:07

10:08

Stephen was bitten twice on this ward. The first time was after about six weeks. He was bitten on the hand by another patient. Someone phoned to tell us at home on a Friday and we saw him on a Sunday during our visit. I can't recall the date or the name of the staff member. We were never told very much about what happened, just that it was another patient and they were separated. They were very short staffed. There was never any investigation. It may have been H31 who was in charge in this ward and he said Stephen should not have been placed on this ward. He was moved a couple of months later to another ward. 10:08 10:08

Dr. H41, a female doctor, assessed his needs and he was transferred. I can't remember the name of the ward he was transferred to. It may have been Moylena as Erne Ward was being built. Stephen was then transferred to Erne Ward which was two chalet bungalows with a corridor between; one female and one male. 10:08

Stephen was discharged to a private nursing home on 31st October 1990. He was admitted back to Muckamore Abbey on 8th December 1999. Stephen was then discharged to the same private nursing home, which goes by a different name now, on 27th April 2000. While Stephen was in this place, he was given the wrong food. They didn't diagnose that he was coeliac and he lost a lot of weight. Several staff members at that home came from Muckamore. I believe that H32 set it up and H33 worked there. I am aware of an assault allegation against H33. When Stephen was in Ballyclare I witnessed a girl in agony during one of my Sunday visits. I called the inspector and reported this. I think his name was H34. I subsequently saw that there was a court case and that H33 had broken the girl's jaw. 10:09 10:09 10:09

Stephen was transferred to another care home in..." 10:10

- and you name the town:

"...shortly after this for approximately 2 months. After that he was in a home in another town for approximately two weeks before returning to Muckamore on 20th December 2000. Stephen likes to have company and he shared a room with another patient. 10:10

In 2001, Stephen's roommate died and Stephen was very

sad about this. He had always been used to company. This wasn't explained properly to Stephen and he became depressed.

In 2011, in Muckamore, Stephen was bitten again on the arm. Stephen would not move quickly and would not know to move away. A nurse phoned to tell us. Pauline, I think. I don't know if an investigation was carried out. However there should be CCTV of the incident as cameras were installed in 2003. 10:10

There was another incident in 2011 or 2012 where Stephen had his arm scratched by another patient and it had scabbed over. My parents and I noticed it on a Sunday visit. We asked the staff, I can't recall who, and they said that he had been in a fight with another patient whilst eating. I don't know if there was any investigation carried out. 10:11

There was another incident in Muckamore, I can't recall the date, but it was after he returned from the second care home that I mentioned, where Stephen was found by the night staff under the bed. Stephen was not hurt. We were told that he had fallen out of bed during the night and the mattress was on top of him. This was because he was in the wrong bed. We complained to the staff and they changed the bed straightaway. 10:11

Stephen would sit on the floor with his back to the

wall, hit the wall with his arms. This started after he was in the first care home and we think this was a punishment in there.

On 7th May 2013, we were informed by Muckamore that he had broken his arm. They said they did not know how it happened. We were told that Stephen was pointing to his arm and saying "sore". He could not say much more. I believe that Nurse Deirdre Keegan telephoned to see how Stephen was as she was concerned about him. 10:11 10:12

Stephen was taken to the Royal Victoria Hospital. The doctor who treated him was..."

- and you name the doctor. 10:12

"...and he said he suspected it might have been caused by repeatedly hitting his arm on a wall or table. Stephen had a temporary cast put on. During Stephen's time in The Royal there was always someone with him from Muckamore, 24/7, either H35 or H36. 10:12

On 14th May Stephen had an operation to fix his arm. He had three plates and twenty screws put in. He was released from The Royal back to Muckamore on 15th May. 10:12

On 24th May he went back to The Royal where an x-ray showed that a screw had come loose. He stayed in hospital and had another operation on 31st May to fix

the screws. On 8th June he had a plate removed and a brace fitted. On 14th June, an X-ray revealed that Stephen had another break above the original break in the same arm. On 20th June he had a review with a doctor at the RVH, at The Royal, who advised that he needed another operation for the fracture."

CHAIRMAN: Just pausing for a moment. I think you said the 20th June. It should have been the 28th.

MR. McEVOY: 20th. 28th. No, it is the 28th. 10:13

CHAIRMAN: Thank you.

MR. McEVOY: The accident, Chairman.

"Stephen had the operation on 17th July. Went downhill very quickly after that and on 20th July he had to have a blood transfusion. 10:13

On 21st July a larger plate was inserted into his arm, which was the fourth plate to be put in. Stephen was okay after that and returned to Muckamore on 25th July with instructions regarding wound management. 10:13

On 27th August, Stephen was admitted to The Royal again with an infection in his arm. The Royal Staff advised me that Stephen's wound hadn't been cleaned properly at Muckamore. He was put on a drip and needed 6 different antibiotics for the infection. 10:13

On 3rd September, Stephen was reviewed by the doctor at

The Royal. He was not pleased with Muckamore's care of Stephen's arm and said they should have seen the signs of infection earlier. Stephen was put on antibiotics for six weeks for the MRSA infection. Stephen's arm was washed out on the 10th and 25th September but it did not work. His white blood cell count dropped dramatically and he was on death's door. The doctor at The Royal advised myself and my parents on 2nd October that in order to save Stephen's life they would need to amputate his arm. 10:14

The operation was carried out on 4th October and it was a success. Stephen now has a stump high up. He has phantom pains but can't really tell anyone. He doesn't understand fully and thinks he still has his arm. 10:14

The doctor at The Royal would not release Stephen back to Muckamore. A social worker, a social worker at the Northern Health and Social Care Trust, dealt with his placement. Stephen was taken to a resettlement residence in a certain town on 21st October 2013 without informing anyone in the family. We were not given any choice or options. At that stage it was a new building and it wasn't completed for another two years. He was on his own for several weeks and then another patient came. A further patient came two years later. There was no day care and they had to sit in one room. 10:15 10:15

I phoned Muckamore on 21st October about the investigation but they would not say anything more to me. The social worker tried to find out more information about what had happened, but no one would speak up. Dr. H41 from Muckamore rang us afterwards to say that she thought that the resettlement residence was the best place for Stephen.

A doctor is now in charge of Stephen's care at the resettlement residence but he never comes to see him. He is an ordinary GP and it is just community care. There are not enough staff and they do not have appropriate training. H37 from Muckamore came to the resettlement residence to train the staff on behavioural issues. He recommended that he is moved from the sofa as Stephen has bed sores. I've tried to get occupational therapy involved but I couldn't get anything done with COVID. The OT wasn't replaced after maternity leave. I even had to get him a wheelchair from the Red Cross and I often have to fix things or buy things for the home.

My family and I thought that Stephen's care in Muckamore was okay, apart from the incidents I have described in my statement. I thought that the staff were good but I did not realise all of the issues that were going on. My main concern regarding Stephen's care at Muckamore was that his broken arm was not treated properly by the staff at Muckamore and it had

to be amputated. I believe this was due to the neglect at Muckamore. There must have been investigations regarding this but we were not told about them.

We did make contact with the police about it. In 2013 the patient counsellor contacted the police about Stephen's broken arm at Muckamore. The police then contacted us and said they would need to talk to Stephen, but we told them that he couldn't explain what happened. They said it was a civil case and we didn't hear anything further from them. We didn't pursue it further." 10:17 10:17

So, Ian, at the start of your statement you drew the Inquiry's attention to a photograph. Do you have a copy of the photograph before you? Can you just point out to us, just for the Inquiry's benefit, who all is in the paragraph? 10:17

A. That's my brother, Stephen. 5.

10 Q. That's Stephen. 10:17

A. And that's his father, and his mother, and his grandmother and grandfather.

11 Q. Can you tell us when the photograph was taken?

A. That's the first day when he moved into that ward in 1988. 10:18

12 Q. So that was taken at Muckamore.

A. Yes.

13 Q. Was there something you wanted to say about the environment behind the people in the photograph,

including Stephen?

A. Yeah. Well these windows are like the prison ones, but they're solid steel. Reinforced steel. And even the door going into it was solid steel, with just a wee small 4-inch window at the top of it to look in. All the doors were locked. It wasn't a good environment to be in. You know it was just a big open room. Only four chairs that we had to sit in. It wasn't very comfortable. 10:18

14 Q. And you had described how the other patients in the ward at a time, you described them I think as violent. 10:18

A. Yeah, you could hear a lot of shouting, you know, and arguments going on all the time when you were in that ward.

15 Q. To your knowledge was Stephen ever classified or characterised as a violent patient? 10:18

A. No.

16 Q. Okay.

A. Stephen would hit out at people if they came too close to him and he didn't know them, but that's just a defence mechanism. He wasn't violent in his nature. 10:19

CHAIRMAN: Before we move on, Mr. McEvoy, can we just establish what that room was used for, because I'm not -- was it just used for this photograph or was it the ward in which Stephen was cared? 10:19

MR. McEVOY: Can you hear the Chair's question, Ian?

A. Yes. That's the main room that all the patients were kept in. The sleeping quarters were separate, but we weren't allowed to see them.

17 Q. So was it like a day room as such?
A. Yes. That's the only room you were allowed to go into. They wouldn't let us in any other room.
18 Q. So that's where, if you went on a visit, which is obviously what is taking place there, that's where you would have been taken to? 10:19
A. Yeah.
19 Q. And that's where you would have interacted with Stephen?
A. Yes. 10:19
CHAIRMAN: Thank you. Thank you.
A. But we weren't allowed to go every week to see him in that ward.
MR. McEVOY: Okay.
A. And it was strict on when you could go and visit him. 10:19
20 Q. How often were you able to go an see him?
A. Once a month. Where normally we'd have seen him every week, you know.
21 Q. Okay. While he was in that ward, I think you had indicated I think in the body of your evidence that there was an incident, and this was the incident involving the bed. 10:20
A. Yes.
22 Q. And in the body of your statement you weren't able to recall the date when the incident with the bed took place. Can you shed any light? Have you had an opportunity to jog your memory about when that might have been? 10:20
A. It was just in the first few nights of him staying in

that locked ward. It was an army bed they were in. Like a steel framed camping bed. But it had no sides on it and Stephen fell out and the bed collapsed on top of him. He was lying there all night. Nobody had copped on that he had fallen out of the bed until the next morning. Luckily enough Stephen wasn't harmed, you know, he was okay, but a staff member should have been there to see, you know, what was happening during the night. 10:20

23 Q. So what year approximately would that have been, just so the Inquiry is clear? 10:20

A. Well that was around Christmas time when he was admitted, so it would have been around December '88, 1988.5.

24 Q. All right. Thank you. I was asking you a moment or so ago about whether Stephen could ever have been characterised as a violent patient, and your answer quite firmly was no. But in terms of Stephen's ability to communicate with others, could you describe a bit more about that for the Inquiry? 10:21

A. Stephen's vocabulary is very limited. He knows about six words, you know, that's all he can say. But he can point to things. He used to use Makaton language, you know sign language, but then that wasn't carried through at Muckamore. He was taught that at the school he went to when he was younger. 10:21

25 Q. Yeah.

A. So unless people knew him, it was very hard to get to know what he wanted, you know. We knew exactly what he

wanted, you know, we could understand him.

26 Q. And if...(INTERJECTION)?

A. If Stephen had a new staff member he would really take to them and do anything for them. But if a staff member was starting to abuse him, he wouldn't do anything for them and try and stay away from him. 10:21

27 Q. Just on the point about the Makaton. Was it used at all at Muckamore?

A. No, it wasn't. No.

28 Q. None of the staff members even knows he was familiar or got on well or used it? 10:22

A. Yeah. No. It wasn't until he moved into this latest home he is in now that they started to use pictorial signs, so the likes of food or wanting to go to the toilet or get washed. He would point to the one he wanted then. 10:22

29 Q. Yes. Yes.

A. But that's only since he moved into this new home he is now. Muckamore, the whole time he wasn't given that chance. 10:22

30 Q. I know you have talked about it in the body of your statement in relation to the incident involving Stephen's arm, but if Stephen was in distress or discomfort, would he be able to communicate that and, if so, and if so, how would he do that? 10:22

A. Like he can say "sore". That's one of the words he can say, and he'll point. So if it was his arm, he'd just point to his arm, or if it was his head sore. He'd just point to it, you know. If it was really bad

he would start crying so you'd know something was wrong.

31 Q. Can you help us, would he only communicate that to people, for example like you, who are family members?

A. No, he'd communicate it to anybody. 10:23

32 Q. All right. Okay.

A. He would just constantly keep saying it. He wouldn't stop, you know.

33 Q. Yeah. Okay. Tell us a bit more about Stephen's personality. How would you describe him? What sort of a chap is he? 10:23

A. Stephen is very easy to get along with, you know. He likes his music, you know. He's always in good company with him.

34 Q. Yeah. 10:23

A. Just his communication is very poor, and his eyesight is not good. He has tunnel vision. So you have to be very close to him so he can make you out, you know, to see who it is.

35 Q. Yes. Yes. 10:23

A. But otherwise he's very good, you know. He gets along with most people.

36 Q. And who all -- in terms of family then, who all is in the immediate family, in Stephen's immediate family, apart from yourself? 10:24

A. Just the parents are still alive. So we visit him every Sunday now.

37 Q. And Stephen will be 54 coming on his next birthday, is that right?

A. Yeah, in October, yeah.

38 Q. Okay. Where are you in relation to him then?

A. I'm the younger brother.

39 Q. Okay. Are you seeing him often at the moment?

A. Yeah, every Sunday we go to visit him. But during COVID we weren't allowed in to see him, you know, because of the pandemic. 10:24

40 Q. Yes.

A. So we didn't see him in person for 25 months, so that wasn't easy. 10:24

41 Q. In terms of his general form now, in his new residence, or the residence where he is currently, how is he getting on?

A. Well he has improved since we were able to go up and visit him, you know, just more happier now, you know. 10:24

42 Q. Yeah.

A. He has still got issues that's come back since the home he was in before and then Muckamore, they still keep haunting him, you know. He's not sleeping well at night at all. Most night he sleeps on the sofa. 10:24

43 Q. Did you -- I am sorry, did you say they keep haunting him?

A. Yes. It just he keeps -- he must get flashbacks, I think, you know, from the time he was in those homes.

44 Q. Yeah. 10:25

A. He still cries out if somebody punched him (inaudible) in the homes, you know. Sitting on the floor, keeping your back to the wall, hitting your arms against the wall. That's some of the things he was doing. That

never happened until he went into the home.

45 Q. Yeah. Just...(INTERJECTION)?

A. Then he started to shout a bit more now, more vocal.

46 Q. Those punishments, as you described them, where do you think or where do you feel that those were carried out? 10:25

A. That was that first home after he left Muckamore, the first time. It was that first home he was in.

47 Q. And just...(INTERJECTION)?

A. But we didn't know that until afterwards.

48 Q. That's the home that you described then, I think at paragraph in your -- just for the Inquiry's reference, that's the home described at paragraph 10 of your statement? 10:25

A. Yes. Paragraph 8. That's the first home.

49 Q. Yeah. So it is mentioned there. Then... 10:26

A. It is the same home again in paragraph 10.

50 Q. Same home again at paragraph 10. So the Inquiry understand this correctly, you think that it was some of the staff members in that home came from Muckamore?

A. Yeah. It was the Muckamore staff that started that home up that time. 10:26

51 Q. All right. Okay. In terms of when -- you have described -- I know you gave us some description of the ward where Stephen was when he went in in 1988, although you haven't been able to remember the name of it, but you've certainly described the environment, but do you know what the name of the ward was where Stephen was based when he broke his arm? 10:26

A. Erne Ward. It wasn't far from the other ward, it was

just 600 yards away.

52 Q. All right. Okay.

A. It was a new purposely-built ward then.

53 Q. In terms of -- obviously we want to try to avoid names, but in terms of the numbers of staff who would have been with Stephen, did you notice any pattern? Was there, as far as you were concerned, a sufficient number of staff there? 10:27

A. Well you would usually regularly see one or two that you recognised every week, you know. 10:27

54 Q. Okay.

A. But then later on in years, when Stephen came back to Muckamore, the staff kept changing very quickly. We didn't know most of the staff then, you know. But in the early years it was constant. We knew who we were talking to every week. They were always very friendly and helpful. We didn't know what was going on behind the doors. 10:27

55 Q. Yes. In terms of that change that you noticed where there was more of a turnover in staff, can you help the Inquiry with when that would have been approximately? We don't need a specific date, but maybe roughly. 10:28

A. I mean that would been, you know, when he went back in. That was in -- I'm trying to find the date here on this. 10:28

56 Q. I think you say he went back in in '99/2000.

A. 2000. December 2000. That's when we noticed a difference in the staff levels.

57 Q. In terms of that pattern of staff -- like a turnover of

staff and you didn't know who they were.

A. No. They were a lot younger staff too. There wasn't so many mature staff about.

58 Q. Yes. So when would that have -- when would that sort of pattern have started of less regular staff, shall we say? 10:28

A. That was -- that's what I'm saying, when he went back in December 2000.

59 Q. So from 2000 onwards?

A. Yeah. Yeah. 10:28

60 Q. Okay.

A. But the day care centre over at Muckamore was very good and it was constant. It was the same staff member all the time.

61 Q. The day care centre? 10:29

A. Yeah. And he really enjoyed that.

62 Q. Would you have been familiar with the staff in there then?

A. Yeah. There was one particular fella, I think it was David we called him. 10:29

63 Q. Okay.

A. He was very good to him, you know.

64 Q. Okay. Okay. I don't have any more questions for you, Ian, but is there anything you would like to say to the Inquiry on your own behalf and, indeed, on Stephen's behalf yourself now? 10:29

A. Well we're just concerned that the Muckamore staff didn't listen to us, you know, when we investigated, you know, what happened his broken arm.

Just everybody seemed to just close doors overnight. They wouldn't return our calls or anything, you know, so we just got a bit worried about what else was happening. We didn't know about, you know. This is why I brought this case forward today.

MR. McEVOY: Okay. Thank you very much.

A. He can't speak for himself, so I mean I have to speak up for him.

MR. McEVOY: Yes, of course. Of course. It may be that the members of the Panel have some questions for you?

END OF DIRECT EXAMINATION

CHAIRMAN: I've got a few questions before I turn to my colleagues.

IAN (BROTHER OF PATIENT 3) WAS THEN QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS

CHAIRMAN: Ian, can you hear me all right?

A. Yes.

65 Q. In your paragraph 13, you say -- at the end of that paragraph you talk about the occasion in 2011 when Stephen was bitten again on the arm, and then you say you don't know if an investigation was carried out:

"However there should be CCTV of the incident as cameras were installed in 2003."

Can you just tell us, what gave you the impression that cameras were installed in 2003?

A. That was the social worker was able to tell us that. But we asked her to investigate it to see if she could find out what had happened. That's what she came back and told us, that there was actually cameras were installed around that date. 10:30

66 Q. All right. Which ward was that in? Do you remember?

A. Erne. Erne Ward. 10:31

67 Q. That was in Erne Ward. All right. Just give me a second. When Stephen got his arm infection and he went to RVH, The Royal, did you make any attempt to follow that up with Muckamore?

A. Yes. I phoned Erne Ward and kept asking, you know. Every night we were on the phone with them to see how his condition was. They always just kept telling us he was in good form and his arm was looking okay. 10:31

68 Q. Yeah. I mean you told us -- we can see that there was an investigation, but did you ever get the results of that investigation? 10:32

A. No. We were never told about it. They never came back to us about it.

69 Q. Were you ever asked to contribute to that investigation? 10:32

A. No. We weren't, no. In fact some of the nurses that used to work in Muckamore phoned us afterwards to see if we had heard anything. Again, we couldn't tell them because we didn't know. There was one nurse who was

very worried about him. She stayed with him in the hospital during that time.

70 Q. Then also, you mention in paragraph 28 about the broken arm and whether there was an investigation in relation to that. But, again, did you have any information about whether there was an investigation or not? 10:32

A. No. They never told us. We kept asking but they wouldn't tell us anything.

71 Q. I don't want you to name names, but who were you asking? Was it nurses or was it senior staff? 10:33

A. It was the staff member in charge of the ward.

72 Q. Right.

A. They always passed you through to the senior member every time you phoned in to speak to them.

CHAIRMAN: All right. Just give me a second, would you? Prof. Murphy has got a question for you. 10:33

73 Q. PROF. MURPHY: Thank you. You said in answer to some of the questions you were asked that you were told you could only visit once a month to that first ward your brother was in. Have I understood that right? 10:33

A. Yes, that's right. Yes.

74 Q. And did they say why?

A. No. They just said you had to arrange it by appointment and there was only so many appointments they would give out, because it was to that ward and because that was the first time he was away from home that we were only allowed to visit once a month. 10:34

75 Q. I mean that must have been very hard for you, because you're obviously a very committed family. Were you

able to visit once a week in the other wards?

A. Yes.

76 Q. So it was just that first ward where you were told you couldn't?

A. Yes. 10:34

PROF. MURPHY: Okay. Thank you.

CHAIRMAN: Sorry, I don't think the camera was pointing in the right direction. I'm grateful to the secretary to the Inquiry. You couldn't see any of us, but you can now. 10:34

A. No. I can see some of you now, yes.

CHAIRMAN: All right. Apologies for that, Ian.

I think formally we ought to ask you, do you adopt your statement? In other words, do you want your statement to form part of your evidence to the Inquiry? 10:34

A. Yes, please.

CHAIRMAN: Yeah. All right.

END OF QUESTIONING BY THE INQUIRY PANEL

10:35

CHAIRMAN: Well, unless there's anything else from counsel?

MR. McEVOY: No, thank you.

CHAIRMAN: No. Ian, can I thank you very much for -- I was going to say coming along, you haven't come along, but you're sitting at home, but for making yourself available to the Inquiry and to say your bit on behalf of Stephen, which has been really helpful to us. So, can I thank you very much indeed. 10:35

IAN: Yes. Thank you very much for listening.
CHAIRMAN: All right. You can now turn your camera off and I think we can close the connection. Thank you very much, Ian.

10:35

THE WITNESS WITHDREW

CHAIRMAN: Right. Can we move straight on or do you need a break?
MR. McEVOY: We're in the hands of the Panel. It may be that a short break might be useful just to set positions up. I think there are some exhibits and so on. 10:35
CHAIRMAN: Oh, are there? All right. Okay. I'd like to start sort of fairly promptly because we haven't been going very long, but certainly if you need a short break, that's fine. 10:35
MR. McEVOY: Ten minutes might be more than adequate.
CHAIRMAN: Ten minutes. Okay. Well we won't take the sort of morning break now. We'll just stop for ten minutes and let you sort that out. 10:36
MR. McEVOY: Thank you, Chair.
CHAIRMAN: Sorry, who is dealing with the next witness?
MS. ANYADIKE-DANES: Sorry, Chairman, just before you rise. I want to apologise for coming in late into the chamber, and as a result, my team were late. 10:36
CHAIRMAN: That's all right. Don't worry.
MS. ANYADIKE-DANES: I know that you really want us all to be prompt and it interferes with the smooth running

of things when people are not prompt, and I apologise for that.

CHAIRMAN: Thank you for the courtesy of the apology. In fact, because the witness was on camera, I don't think you disturbed anything. So, thank you. All right, ten minutes. 10:36

THE INQUIRY ADJOURNED BRIEFLY AND THEN RESUMED AS FOLLOWS

10:40

CHAIRMAN: Thank you. Yes, Ms. Briggs.

MS. BRIGGS: Yes. Good morning, Panel. My name is Sophie Briggs. I'm going to be reading this morning from the statement of P10's sister.

CHAIRMAN: Just give us a second, could you? Are there any exhibits for this? 10:50

MS. BRIGGS: Yes, there are multiple exhibits, Chair, attached to the statement. The statement itself, Chair, starts at reference MAHI-STM-020-1, and the exhibits follow thereafter. 10:51

CHAIRMAN: All right. Just give me a moment. Thank you. How is the witness going to be known?

MS. BRIGGS: The witness is known as P10's sister, Chair.

CHAIRMAN: P10, is it? 10:51

MS. BRIGGS: P10. Yes, Chair.

CHAIRMAN: Okay. Thank you. Thank you very much. Okay.

MS. BRIGGS: Thank you, Chair.

STATEMENT OF P10

MS. BRIGGS: The statement starts:

"I P10's sister make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. 10:51

Section 1: Connection with MAH
My connection with MAH is that my sister, P10, was a patient at MAH. I attach a photograph of my sister at P10's Sister 1." 10:52

Panel, we'll call that Exhibit 1 for ease and, Panel, those exhibits start, if I give the page reference, at STM-020-10. 10:52

"Section 2: Relevant time period
The relevant time period that I can speak about is approximately between the late 1960s and 2003. 10:52

Section 3: Information
My sister, P10, is one year older than me. She was born on 7th January 1958. P10 has severe learning difficulties and epilepsy. As a result of her condition she suffers seizures. I recall visiting her regularly in my childhood when she was admitted to MAH from the late 1960s onwards. I do not recall the exact date she was first admitted to MAH. 10:52

P10 lived at home from time to time and would have attended outpatient clinics at MAH quite regularly. P10 is now 64 years old and is living in another facility.

10:53

I have another sister..."

- and we'll call her P10's sibling:

"...in the same home who also has severe learning difficulties. 10:53

Over a period of years my parents visited P10 at MAH most weekends. My parents took me there to see P10 for most of these visits and we would quite often bring a picnic with us and walk in the grounds of MAH with P10. We continued visiting P10 while she was at MAH. P10 was subsequently transferred to the other facility but she would still attend MAH for appointments on a day-release basis. P10 was on a range of medication and up until the last few years she also wore a helmet during her time at the other facility in case she had a seizure and injured her head in a fall. 10:53

P10 has been living in the other facility for well over two decades. However, there was one occasion when P10 was admitted to MAH in or around September 2001. She was there until the 18th April 2002. My parents made a formal complaint about her treatment while she was 10:54

admitted to MAH in 2001 and 2002. They were not happy with her treatment. She was being given so many drugs and was extremely drowsy. She was not her normal self. My parents and I were very concerned about her. I also remember visiting P10 over Christmas time in another facility one year, although I am unsure exactly when it was. She was in there for several weeks. At that time she was having approximately 10 to 20 seizures a day. My parents were told that one of these seizures could be fatal as her heart may not be able to cope. 10:54 10:55

I recall P10 had broken a bone in her foot, which we think had occurred while she had been at MAH, but this was only diagnosed after she was discharged from MAH and when she was in another facility. I do not recall exactly when this was, but I do know that my mother and father tried their best to get P10 out of MAH. I do not believe that there was any contact made by my parents with the police in relation to what happened to P10 at MAH. My parents have repeatedly told me that under no circumstances should P10 or my other sister (who also lives at the other facility) be admitted to MAH after what happened in 2002. My parents repeatedly said this until they passed away. 10:55 10:55

My father..."

- we'll call him P10's father:

"...passed away in December 2016, while my mother..."

- P10's mother:

"...passed away in July 2019.

P10 had been admitted back to MAH in September 2001 from the other facility. She was sent to MAH by ambulance. There were issues with her low potasium and sodium levels. She was then taken to Antrim Area Hospital (AAH) the next day. Approximately two days later she was discharged back to MAH. Thereafter, P10's condition deterred at MAH. I refer to the formal letter of complaint written to the business manager of MAH dated 24th April 2002, which was written by my father, a copy of which is attached at Exhibit 2."

The panel has that Exhibit and I will turn to it shortly.

If I go back to the statement, Panel:

"In this correspondence my father stated that whenever P10 was admitted to MAH after her stay in AAH her health deteriorated and as the "days, weeks and months passed she got worse and worse until she could not walk, her speech was slurred, slobbers leaking from her mouth, eyes rolling in her head, head nodding, unable to feed herself. Indeed, she became a danger to

herself as she did not appear to be able to swallow and was choking on her food."

My father went on to state in this correspondence that they were misled by the doctors and nurses at MAH, including being misinformed that H40 of MAH was regularly in touch with the doctor who had treated P10 at the RVH. This was untrue." 10:57

Panel, I'm going to read a little bit more from that exhibit. If we turn, Panel -- the exhibit starts at MAHI-STM-020-12. It's internal page reference 12. 10:57

CHAIRMAN: This is the letter, 24th April.

MS. BRIGGS: This is the letter from -- that's right. 10:58

If we turn over the page, Panel, I've already read much of that first paragraph, Panel. I'm going to just read some of the remainder of that page of the letter.

If we go to the second paragraph, P10's father writes as follows: 10:58

"P10 was left sitting in a chair all day with her head resting on her shoulder or cushion, resulting in her being reduced to virtually a vegetable. We were consistently told by the doctors and nurses that she was improving, despite our warnings and concerns that she was not. It was clear to us that it was the medication prescribed by your doctors that was causing 10:58

her to be in this state, but they would not listen despite our many protests. At one stage of P10's treatment she was put on antidepressant Amitriptyline. Never, ever in our lives do we want to see any person or persons in this disoriented state. This was over a period of two or three weeks. 10:59

On several occasions we asked to see H42 about P10's condition, and I must say that we were not at all impressed with his answers or manner. We also asked to see H40 on various occasions about P10's condition. He informed us on each occasion that he was in touch with a doctor at The Royal. We subsequently discovered from The Royal that this was not the case." 10:59

10:59

Panel, if I skip then -- the Panel has the remainder of that paragraph, but if I just read the final paragraph on this page for the purpose of the record, Panel?

CHAIRMAN: Yeah.

MS. BRIGGS: 10:59

"We also had a three-quarter hour meeting with H41, who really brainwashed us into believing that this was the way that P0 would be and only medical fine tuning was required. We stressed that this was not P10's usual state, but to no avail." 10:59

The Panel has the rest of that exhibit. I'm going to turn back to continue to read the statement, Panel, and

we're at paragraph 9 on the third page of the statement:

"We knew that P10 was very unwell and that her medication was not helping. In his letter of complaint to the business manager at MAH, my father wrote that he and my mother travelled from a place to MAH every day for several weeks and had to reduce their visits to every other day as they could no longer take what they were seeing. At this stage my mother ended up in hospital herself with anxiety. My parents were both extremely frustrated with what was happening as MAH continued to ignore their concerns. They believe that the people at MAH were dishonest. 11:00 11:00

P10 was admitted to the RVH on 12th March 2002. She was in MAH before this and had been discharged from MAH and admitted to the RVH. I remember a nurse telling me that she was totally overdosed with medication. She was in "a totally drugged and vegetative state", as per my father's comments in his letter of complaint of 24th April 2002." 11:01

And that's Exhibit 2, to which the Panel have already been referred. 11:01

"Within days of being at the RVH, P10's health improved so dramatically "it was just unbelievable". In a week or two she was back to her normal self as the doctor

continued to further reduce her Epilim. A doctor and another doctor of the RVH advised my mother that they had only received one phone call from H40 of MAH, which was made appropriately one week prior to P10's admission to the RVH on 12th March 2002. This contradicted what my parents had been told by H40. 11:01

P10 left the RVH on 18th April and was back to her normal happy self. She quickly settled back in to the other facility. She had spent five months in MAH with absolutely no improvement, and yet after only five weeks in the RVH she was so improved that she could be discharged. 11:02

My parents received a response to their complaint letter of 24th April 2002 on 10th May 2002 from the Director of Hospital Services at MAH, a copy of which is attached at Exhibit 3." 11:02

P10's Sister 3. I'm very briefly going to turn to that one, Panel. It is at internal reference MAHI-STM-020-16. It is internal page 16. And in that letter it can be seen that the Director of Hospital Services invites P10's parents to a meeting with the business manager of MAH to explain the process by which the complaint will be investigated. 11:02

If I leave that there, Panel, and turn back to the statement.

CHAIRMAN: Could you just give me a second, I'm sorry. I just want to have a look at that letter.
MS. BRIGGS: YES.
CHAIRMAN: Is that 10th May 2002?
MS. BRIGGS: 10th May 2002. 11:03
CHAIRMAN: Yeah. Okay. Yes. Thank you.
MS. BRIGGS: Thank you, Chair.

If we turn back then to internal page 4, it is STM-020-4. We're at paragraph 12 on the third line: 11:03

"My father responded with a letter of 15th May 2002 being their proposal of a meeting, a copy of which is attached at Exhibit 4."

11:03

The Panel has that in their papers.

"My father heard from MAH complaints process which promised that a complaint would be responded to fully in writing within 20 working days. My father stated 11:03 that unless a detailed reply was provided within the relevant time scale, then the matter would be referred to the Ombudsman.

A letter was received from the Director of Planning, 11:03 who was based at the Trust Headquarters in Murray Street, Belfast. This correspondence was dated 21st May 2002, and a copy is attached at Exhibit 5."

Again that is in the Panel's papers. It is internal reference STM-020-18. I'm not going to turn to it, Panel, I'm just going to continue to read.

"In this correspondence it was confirmed that the Director of Nursing be asked to investigate my parents' complaints, along with an independent consultant psychiatrist who was from Armagh and Dungannon Trust. 11:04

The investigation process was delayed for quite some time. My father wrote a number of letters to The Trust seeking progress, including a letter dated 10th October 2002 to the Director of Nursing, a copy of which is attached at Exhibit 6." 11:04

11:04

Again, the Panel have that.

"In this correspondence my father pointed out that it was now 24-weeks since the initial complaint was made and that they were compiling paperwork to send to the Ombudsman and their local MLA. 11:05

A report dated September 2002, and prepared by the Director of Nursing, was issued by the Chief Executive of The Trust by way of a letter dated 10th October 2002. The report, a copy of which is attached at Exhibit 7..." 11:05

P10's Sister 7:

"...was in our view a whitewash."

Panel, I'm going to turn to this one. It is at internal reference MAHI-STM-020-20. It starts at that page, Panel, and it runs on for some ten pages. The Panel has it in full, but if I just direct the Panel to the penultimate page at STM-020-29. 11:05

CHAIRMAN: Okay. Just hang on.

MS. BRIGGS: Yes. 11:06

CHAIRMAN: Sorry, because of the screen the pages at the top have been -- disappeared. What's the internal page numbering at the bottom?

MS. BRIGGS: 29.

CHAIRMAN: That's the internal page numbering at the bottom, is it? 11:06

MS. BRIGGS: Yes. On the document itself, it's the 9th page of the document itself.

CHAIRMAN: Yeah. Yeah. Got it. Thank you.

MS. BRIGGS: Chair, those are the conclusions that are written by the Director of Nursing. I don't propose to read them in full but to merely point out, Panel, that that's where they are, and the Panel has the remainder of the report. 11:06

Panel, if I return then to the statement at paragraph 14. We're four lines down there, Panel.

"My parents wrote a letter dated 30th November 2022, a copy of which is attached at Exhibit 8."

And the Panel has that. And that starts, Panel, at internal page reference 31, STM-020-31. That letter -- 11:07
if I return to the statement:

"...rejected the report issued by the Director of Nursing and rejecting the opinion that P10 had received the professional care she was entitled to from the 11:07
doctors in charge in MAH. They believed that there were a number of questions that were unanswered in the report. This was a three-page letter and it outlined a number of inaccuracies and inconsistencies in the account provided in the report issued on behalf of 11:07
The Trust.

My parents believed that the investigation was incomplete and inconclusive, particularly because no contact had been made with the doctors -- two doctors 11:07
of the RVH.

The Chief Executive acknowledged my parents' letter of 30th November 2022 under cover of correspondence dated 4th December 2002, a copy of which is attached at 11:08
Exhibit 9."

And the Panel have that.

"However, the matters seemed to drag on for several more months and my parents became increasingly more frustrated. My parents also wrote a letter to the North and West Belfast Trust's Chief Executive on 12th May 2003, a copy of which is attached at Exhibit 10." 11:08

Again, the Panel have that in their papers.

"In this correspondence my parents repeated some of their concerns about the report that had been produced. 11:08
The final paragraph is very pertinent as it highlights that during her time at MAH, P10's health was deteriorating at an alarming rating and my parents stated that it was "unforgiveable for H41 and H40 to have let P10 get into such a pitiful state as her 11:09
welfare had been placed in their hands. The very least we could have expected was an apology for the distress P10 and ourselves experienced."

Eventually a letter dated 16th May 2002, was issued by 11:09
the Chief Executive was sent to my father requesting a meeting with the relevant medical staff from MAH and the investigating officer, the Director of Nursing, a copy of which is attached at Exhibit 11."
11:09

And the Panel have that. It is internal page 36.

"It is clear from correspondence issued by the Chief Executive on 1st July 2003 that my parents had a

telephone call with him towards the end of June 2003. In this correspondence, a copy of which I have attached at Exhibit 12..."

– which the Panel have:

11:09

"...my parents had a frank exchange with him. The Chief Executive offered a meeting with the Non-Executive Director of the Trust and the new Director at MAH. My parents rejected the offer of the meeting by way of correspondence dated 8th July 2003, a copy of which is attached at Exhibit 13."

11:10

The Panel has that also.

"In this correspondence they stated that there would be no point in this and that "we will never get a truthful answer to our original question: Why P10 was kept in a drugged state for over 5 months?"

11:10

My parents decided to bring an end to the matter, but made it clear in this correspondence of 8th July 2003 that "we most definitely feel that the medical treatment that P10 received was far from satisfactory."

11:10

My parents believe that the doctors and nurses at MAH were negligent in their treatment of P10. They steadfastly refuse to attend meetings at MAH and refused to give permission for P10 to attend any day

release clinics at MAH after what happened to P10. The improvement and transformations in P10's health was rapid once she had been admitted to the RVH."

Panel, then P10's sister gives a declaration at the end that the contents of the statement are true to the best of her knowledge and belief, and she says that she has produced all documents which she has access to and which she believes are relevant to the Inquiry's Terms of Reference and, Panel, the statement is then signed and dated 20th May 2022. 11:11 11:11

CHAIRMAN: Thank you.

MS. BRIGGS: Thank you, Chair.

CHAIRMAN: What's happening next?

MS. BRIGGS: Chair. Yes, the Panel is due to hear next from Ms. Tang from the Inquiry counsel team, who will read the statement of P6. If the Chair wishes to have a short break, we can do so? 11:11

CHAIRMAN: Now, I think we will have a break now, in fact before the next statement is read, because that's actually -- is that the last witness this morning and then we've got a live witness this afternoon. 11:11

MS. BRIGGS: That's right, Chair.

CHAIRMAN: Let's take the morning break now, and we'll give it until just after half past. Thank you. 11:12 Mr. Doran, if we could have a word at some point? Thank you very much indeed, Ms. Briggs. Thank you.

MS. BRIGGS: Thank you.

THE INQUIRY ADJOURNED BRIEFLY AND THEN RESUMED AS FOLLOWS

CHAIRMAN: Ms. Tang.

MS. TANG: Good morning, Chair. Good morning, Panel. I'm Shirley Tang. The next statement has been made by a former patient of Muckamore Abbey Hospital, whose named has been redacted and who has been given the cipher P6. 11:32

CHAIRMAN: Could you just keep your voice up because that microphone isn't picking up. 11:32

MS. TANG: How is that, Chair?

CHAIRMAN: Thank you very much. Just give me a second to get this set up. And we are referring to the witness as? 11:33

MS. TANG: We are referring to the witness as P6.

CHAIRMAN: There are no exhibits on this one?

MS. TANG: There are no exhibits.

CHAIRMAN: Fine. Thank you.

MS. TANG: The first page of P6's statement is numbered MAHI-STM-009-1. P6 has asked not give evidence in person, and therefore their statement is being read into evidence. 11:33

STATEMENT OF P6 11:33

MS. TANG: The statement reads as follows.

"Statement of P6 dated 31st March 2022.

I, P6, make the following statement for the purpose of the Muckamore Abbey MAH Inquiry. There are no documents produced with my statement.

11:34

Fiona Paterson, registered intermediary, attended with me when I was making my statement.

Section 1: Connection with MAH

My connection with MAH is that I am a former patient at MAH. 11:34

Section 2: Relevant time period

The relevant time period that I can speak about is between 2016 and 2017. 11:34

Section 3: Information.

I was born on..."

- and the date of birth is redacted. 11:34

"...and am now aged 42. I have a history of learning difficulties, autism, epilepsy and depression.

I was admitted as a patient to MAH in 2016. I was a patient there for over one year. I was a full-time patient. I was in the Cranfield Ward and was in a room by myself. I lived with my nanny before going to MAH. I was brought to MAH by ambulance but my nanny was not 11:34

allowed to come with me. I agreed to go in the ambulance because I was promised that when I got to MAH I could see my nanny to say good-bye. When I got to MAH I was told that I could not see my nanny to say good-bye. I was really upset that they broke their promise. They should have let me say good-bye. I do not remember the name of the person who told me this but it was a fat, plump woman. I was so upset that I threw a tantrum and threw a chair. They should have let me say good-bye. They broke their promise and it really upset me. 11:35 11:35

There were times when I was taken into a separate room that was not my room and was raped by members of staff. When I say that I was raped, I mean that they would make me take my clothes off until I was naked when I did not want to. They would use their hands to feel around my body. I was not comfortable when they did this. I was very tense. They should not have done this to me when I did not want them to. I do not remember the names of the members of staff who did this. There was one man and a few women. When I asked them why I had to take my clothes off they said that they wanted to make sure I had nothing sharp on me that I could use to hurt myself. When I said that I did not want to take my clothes off they told me that if I did not do as I said I might not get... This happened two or three times during my stay. 11:35 11:36 11:36

I did not tell anyone in MAH that this happened as I was afraid. When my nanny came to visit me we would go to the café in MAH. When she asked how I was, I told her I was okay, but I was just trying to cover up what happened. I told my nanny that they raped me when I got out of MAH, but she did not believe me. I did not tell anyone else because if my nanny did not believe me then who else would? 11:36

When I was in MAH I was told to look after another patient. I do not remember who told me to do this. The patient was older than me. She would take her clothes off. I was told that I had to try and stop her from taking her clothes off by taking out a game. Sometimes I stopped her and sometimes I did not. I did not want to do this and it should not have been my job, as I was a patient. It was the nurse's job. I was told I had to do it. 11:37 11:37

During my stay in MAH I had to wash and clean tables. I do not remember who made me do this. I was not allowed to have my phone during my stay in MAH. I was told that I was not allowed to take photographs. I do not remember who told me to do this." 11:37

And the witness indicated that she did not want to give oral evidence to the Inquiry and that she didn't want her name to be read out.

The final section:

"Section 5: Declaration of truth."

- is that: 11:38

"The contents of this witness statement are true and to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are relevant to the Inquiry's Terms of 11:38 Reference."

It is signed P6 and the date is 22nd April 2022.

CHAIRMAN: Right. Thank you very much, indeed. 11:38

I think this afternoon we've got a statement -- is it relating to P13?

MS. TANG: Yes, this afternoon sister of P13 is going to be giving evidence, and Ms. Kiley will be taking her through that evidence. 11:38

CHAIRMAN: Right. Okay. And there's nothing else for this morning?

MS. TANG: Nothing else for this morning. Thank you, Chair.

CHAIRMAN: All right. Okay. Well thank you very much, 11:38 indeed, Ms. Tang. We'll meet again at 2:00 o'clock. Thank you.

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED, AS FOLLOWS, AFTER THE LUNCHEON ADJOURNMENT

[redacted] 14:03

[redacted] 14:03

[redacted] 14:03

[redacted] 14:04

[redacted] 14:04

SHORT PAUSE IN PROCEEDINGS

CHAIRMAN: It is just the solicitors for the witness remaining and counsel. Now, just to establish who is in the room. We have the stenographer, we have counsel and we have solicitor who represent the witness, and we have junior counsel to the Inquiry, Denise Kiley. 14:06

MS. KILEY: Yes, Chair. The secretary to the Inquiry will soon be joining us. The witness has also...

CHAIRMAN: And the Secretary. I don't think -- I'm not sure if we need the screens now, do we?

MS. KILEY: No. 14:06

CHAIRMAN: No. Oh, I see. Okay.

MS. KILEY: Chair, the witness has also asked that she be accompanied at the witness table by the family liaison officer.

CHAIRMAN: All right. Just pause for a second to let people see this part of the proceedings. So just hold on. Sorry, it is the first time we've done this. 14:06

Right, is the feed now running to Hearing Room B. Okay. I'm just going to repeat what I've just said. 14:07

We now have counsel and solicitors for the witness present. The stenographer is present. The Panel, obviously, are present. The audiovisual technicians are present, and we have Denise Kiley, who is junior counsel to the Inquiry present, and shortly the witness is going to be brought in by the secretary to the Inquiry. Those are the only people present. And we have -- just for the record, we have cleared Hearing 14:07

Room A of Core Participants, and they have all moved to Hearing Room B. I gather the parents of the witness are also now entering the room, simply to be there to give support.

MS. KILEY: They are, Chair. When the witness enters the room, she will be also be supported by the family liaison officer, who will sit with her in the witness box, but who understands that her role is simply as a support role. 14:08

CHAIRMAN: That's fine. All right. Just hold on a second. If you'd like to take a seat? Thank you. 14:08

MS. KILEY: Chair, this is the parents.

CHAIRMAN: Yes. Thank you. Nice to see you. Thank you for coming along. Okay. Can we get the witness in. 14:08

MS. KILEY: Chair, for the record, the witness has confirmed that she wishes to be known by her first name, Nicola, and for the patient to be known by his first name, Greg.

CHAIRMAN: And we're dealing with P13? 14:08

MS. KILEY: P13.

NICOLA, HAVING BEEN SWORN, WAS EXAMINED BY MS. KILEY AS FOLLOWS

14:10

CHAIRMAN: All right. Nicola, take a seat. Thank you very much, indeed, for coming along to help the Inquiry. We'll get you a glass of water because I find that sometimes helps.

A. Thank you.

CHAIRMAN: You're going to be asked some questions in a second by Denise Kiley. As you see, we've cleared the room, so only people that have to be here are now here. You know who the Panel is. My name is Tom Kark, and I'm Chair. We have got Prof. Murphy and Dr. Maxwell, to my left. I'm now going to hand you over to Denise Kiley to ask you some questions. If you need a break at any time, just let us know. If you get a bit upset, don't worry about it at all. It happens to lots of witnesses, you're not alone. 14:10 14:11

A. Thank you.

CHAIRMAN: I think once you get started, you might find it a lot easier.

A. Yeah. Yeah. 14:11

CHAIRMAN: All right. Okay.

MS. KILEY: Hi, Nicola.

A. Hi.

77 Q. Nicola, when we met earlier, briefly I explained to you a bit about the procedure today. So, as you know, I'm going to start by reading your statement aloud and then I'll ask you some questions arising from that. 14:11

A. Okay.

78 Q. I explained to you earlier that your brother has been given the cipher P13 for the purpose of your statement, but your parents are here today, isn't that right? 14:11

A. Yes, that's right.

79 Q. And they have confirmed that they would like your brother to be known by his first name, which is Greg,

isn't that right?

A. Yeah.

80 Q. So I'll refer to him as Greg and you as Nicola?

A. That's great.

81 Q. Okay. You made a statement then to the inquiry statement team and it is dated 11th March 2002. Do you have a copy of that in front of you? 14:11

A. I do. I have, yes.

82 Q. So I'm now going to read that aloud and then I'll ask you some questions when I'm finished that. Okay? 14:12

A. Okay.

83 Q. So your statement is dated 11th March 2002, and you say:

"I, Nicola, make the following statement for the purpose of the Muckamore Abbey MAH Inquiry. In exhibiting documents I will use my initials. So my first document will be Nicola 1. 14:12

My connection with MAH is that I am a relative of a patient who was at MAH. My brother, Greg, was a patient at MAH. I attach a photograph of my brother at Nicola 1. 14:12

The relevant time period that I can speak about is between 1980 and 2020. 14:12

Greg was a patient at MAH intermittently between 1980 and 2018. Greg has learning disabilities and his

behaviour can be very challenging at times. Greg has no sense of danger. For example, he has no road sense and would have darted across the street spontaneously. Greg has no literacy or numeracy skill. He has the literacy skills of a 10 or 11-year old. He is 51 years old now.

Greg was first admitted to MAH in November 1980 at the age of 9 years old. My mum cared for Greg at home but found that she could not cope with him on a full-time basis. 14:13

During Greg's stays at MAH we did not have many concerns about his care and were happy overall with his treatment. We felt that MAH was best suited to his needs and had an appropriate nursing care, routine and activities that he enjoyed. Greg never complained to us about his care in MAH. Our main concerns as a family were due to the community settlement scheme. Greg had a number of community placements in various facilities from 1983 to 2018, which I have described below, all of which were unsuccessful as they were unsuitable for Greg's needs. 14:13

Greg's first placement in MAH was between 1980 and 1982. We had no concerns about his care during this time. 14:14

From 1982 to 1985, Greg was placed in a children's

home. We did not feel that his needs were met properly in this home. After this he returned home from 1985 to 1986. However, my mum found Greg hard to manage so he was placed in another facility between 1986 and 1989. They did their best for him at this home but community living did not suit Greg's needs and it was always unsuccessful. They tried him at a range of different activities such as boys brigade, football and scouts, but he was just not able for it. After that he was placed in another facility. This was not suitable for him and they lost him a few times. 14:14 14:15

In 1990 he returned to MAH for a number of years until 1998. We had no concerns about Greg's care during this time. Greg came home to stay with us at weekends, Fridays to Sundays, and was always happy to go back to MAH. If he did not want to do something he would have been destructive, but he was always happy to go back. The nurses did a lot with him. He needed routine and he liked that the staff had uniforms as it was a structured feel for him. Unfortunately, he was put in another community placement under the resettlement scheme. 14:15 14:15

Greg was placed in a children's home. He was there from 1998 to 1999. He settled okay as there were a few people in there who were patients or staff from MAH. I can't recall their names, maybe age 38. Greg was very destructive there and challenging to manage. They 14:15

restrained him a few times and he had bruises and a black eye. The staff, I cannot recall who, told us that he had hit out and struck a light. I am not aware of any investigation that was carried out.

14:16

After that the staff discussed resettlement options with mum. Most of these discussions were with mum as Greg's next of kin. She told them that she didn't think it would work and that we wanted him to go back to MAH. Greg was placed back at MAH between 1999 and 2006. As a family we had no concerns about his care during this time.

14:16

In 2006 MAH moved Greg again to another facility. He was there for around four or five months, but this didn't work out. They did not have day care facilities on site and he had to travel by bus to Portadown. Greg did not like to get the bus and was destructive, breaking a window on one occasion. They took him straight to MAH with a police escort.

14:16

14:17

Greg remained at MAH between 2007 and 2018. We had no concerns about his care at MAH during this time. He generally appeared to be happy and had a daily routine which involved going to day care. He saw it as his home. He did different activities, including swimming, horse riding, baking, etc. He enjoyed getting home most weekends to stay overnight. Greg did have outbursts of challenging behaviour, however these

14:17

seemed to be managed much better by the staff at MAH as opposed to the community placement staff.

On two occasions in 2014 and 2016, Greg had to be detained as his behaviour became very challenging. This was put down to a move between wards. Greg had been in Killead Ward and was moved to Cranfield 2 Ward. Greg found transition difficult and had become increasingly challenging in behaviour. During this period Greg wasn't allowed to come home or leave MAH, but myself and my mum were allowed to visit and take him across to the Cosy Corner café or go for a walk in the grounds of MAH." 14:17 14:18

You then described being contacted by Trust Family Liaison Officer in July 2020 and being informed of two incidents which were recorded on CCTV during July and August 2017 involving Greg. 14:18

A. Yeah.

84 Q. And you confirm that you have not viewed that CCTV. 14:18

A. No.

85 Q. And so as you can't give evidence as to its content, I'm not going to read out paragraphs 18 or 19 of your statement. Okay.

A. Okay. 14:18

86 Q. I'll pick up at paragraph 20.

A. Okay.

87 Q.

"Neither my mum nor I were ever made aware of these

incidents and we were both shocked and upset to hear about them. We had no suspicions or ever saw any unexplained marks. There was only one time where I witnessed Greg having an injury in MAH. He was in the Cranfield 2 Ward. I cannot recall what year this was or the exact date. He complained that his elbow was sore. Greg said that he had fallen out of bed. Mum asked the staff what happened as his elbow was swollen and full of fluid. The staff were not aware of Greg falling out of bed and gave a medical name for why his elbow was swollen, but I do not recall what that was. I am not aware of any investigation being carried out in relation to this incident. 14:19 14:19

Apart from that, Greg never complained or raised concerns about MAH. The staff were very fond of him and if we were down the street in Antrim there would always be someone who knew him. The staff would always ask about him. I cannot remember their specific names. 14:19

In 2018, Greg was moved again under the resettlement scheme. This time he was moved to a supported living facility."

- and you give an address: 14:19

"...from 2018 to 2020. He was resettled on 18th March 2018. We thought this might work out as for around six months beforehand the staff came to visit Greg in

MAH and got to know him. They took him to the cafe and made an "about me" book. Things seemed to be okay for around six months. He settled well at the other facility. There were still behaviours that challenged, but these were well managed. 14:20

However, in August 2019, there were numerous challenging incidents involving physical and verbal aggression and destructive behaviour and a deterioration in his mental health. He started hitting 14:20
out and kicking. He complained of headaches, but any scans were normal. The staff there were not nurses or medical professionals and they couldn't cope with him. Unfortunately, MAH wouldn't take him back and he was formally admitted to Lakeview Hospital, Gransha. He 14:20
was admitted to (inaudible) ward due to the deterioration in his mental health.

Greg underwent a series of scans which revealed that his bowel movements were severely impacted and he was 14:21
treated for this, which could have had implications on his health and cause for his behaviours. He was not himself during this time, and during visits he would tell us to go Home. This was very upsetting. He lost a lot of weight (around three stone). He remained 14:21
there from the 22nd August 2019 until 11th November 2019."

CHAIRMAN: Just pausing for a moment. I presume

there's no difficulty about mentioning that hospital's name?

MS. KILEY: No.

CHAIRMAN: Fine. Thank you.

MS. KILEY: 14:21

"After that he returned to the supported living facility on 11th November 2019. Disruptive behaviours continued and mobility deteriorated. Over the next few months he became increasingly agitated and was verbally 14:21 and physically aggressive to both staff and other tennants. He was a totally different person during this time. We were told that he would throw furniture around, throw his clothes out the window, and was incontinent. This wasn't him. This wasn't Greg. He 14:21 started shuffling and would go a few days without sleep at all. The positive behaviour support team were involved and a support plan was in place but did not ease the behaviours. A doctor reviewed his meds but this appeared to have little affect and Greg appeared 14:22 completely exhausted.

In January 2020 his health went very downhill. Whilst on a visit with my mum at home my mum noticed that he had bruises on his legs. He was not staying over with 14:22 us at this stage. My mum mentioned this to a staff member..."

- and you name the staff member.

"He said that he would document it but he didn't know anything about it. I am not aware of any investigation being carried out.

On 9th March 2020, a bruise and swelling was noticed on Greg's leg and left buttock. A GP appointment was made but they were unable to get an appointment until 18th March and staff monitored the injury. The swelling continued to get worse. This was a very difficult time due to lockdown in March 2020, as due to COVID my mum and I could not visit Greg in the supported living facility so we could not see what was going on. However, one day when I was leaving vitamins in for Greg, he walked past and looked like skin and bone. I was very shocked and upset. A staff member, I cannot recall who, said "I am just checking if Greg can ring your mum". I could hear Greg shouting "I want my mummy". I said to the staff that he needed help and they tried to call the doctor, but they weren't seeing anyone.

Greg attended A&E on 19th March 2020 and they investigated the possibility of a clot, but this was ruled out.

Greg returned to Antrim Area Hospital on 30th March 2020. A staff member, I think her name was..."

- and you give her name:

"Took him to the hospital. He had to be sedated. His bloods eventually showed something after a mixup. He had a large haematoma following a scan and was extremely ill. He needed a blood transfusion and had to have 4 units of blood. It was very difficult to get information or an explanation from the doctors as we weren't allowed in due to COVID. We were told by the staff that Greg was very agitated and confused. Greg was eventually discharged back to the supported living facility on 7th April 2020, but he was returned back to Antrim Area Hospital the same day due to issues with weightbearing. Greg needed nursing care and MAH wouldn't take him back. The other facility were unable to meet his needs when he was discharged from the Antrim Area Hospital on 12th 2020. I attach a photograph of Greg around this time at Nicola 2.

Greg was placed in a nursing home..." 14:23 14:24 14:24 14:24

- and you give the location of that nursing home:

"...on 12th April 2020. This was supposed to be a short-term placement. He was 6 or 7 stone at this stage. They stripped back all of his medication and he started to put weight back on. Within 1 month he started to improve. His mental health has improved and he is back to normal Greg, apart from his mobility. He 14:24

still needs a wheelchair. We fought to keep him here and he was placed there permanently in August 2020.

When the news came out that abuse had taken place at MAH I was surprised but wasn't overly alarmed as my mum 14:25
and I never had any concerns about Greg's care in MAH and he generally seemed happy there.

On one occasion when my mum was collecting Greg from the ward, a member of staff told my mum not to worry 14:25
about the reports as the abuse hadn't happened on Greg's ward, Cranfield 2. I do not know the date or the staff member's name. That is why we were very shocked when we were contacted by the family liaison officer in July 2020 regarding the two CCTV incidents 14:25
in July and August 2017. She asked us if the police had been in touch, which they hadn't at the time, and advised us that had been mistreated. This came as a huge shock to me and my family and I find it hard to believe that this was allowed to happen to vulnerable 14:26
adults in the care of MAH.

It is wrong that my brother and other vulnerable adults had to go through this horrible ordeal, and I believe that the people involved need to be held accountable 14:26
for their actions.

Our main concerns about MAH were regarding the resettlement scheme. The supported living placements

were not appropriate for Greg and always broke down due to his challenging and destructive behaviour towards other residents, himself and staff. We did object to them at times if we felt that they were not suitable or too far away. As a family we felt that they were detrimental to Greg's mental and physical health." 14:26

Then you refer again to the CCTV and ongoing police investigation, and I won't read those final two paragraphs. 14:26

Then in Section 5 you give a declaration of truth, and you have signed that statement and it is dated 7th April 2022. 14:26

So, Nicola, having heard that read aloud, are you happy with the content of that statement?

A. Yes.

88 Q. Do you wish to adopt that as the basis of your evidence before the Inquiry? 14:27

A. Yes.

89 Q. Okay. I have a few questions for you about your statement.

I want to ask you first a little bit about Greg. He is your only sibling, isn't that right? 14:27

A. Yes.

90 Q. And he's 51 now?

A. Yes, that's right.

91 Q. Can you tell the Panel a bit about what he's like?
A. Ehm, well, in his own way he's a very loving brother, but just through his disabilities, learning disabilities, he's very disruptive at times and challenging. He loves to listen to music. He loves watching CDs. He loves Elvis, Daniel O'Donnell, anything to do with those people, but has very challenging behavioural issues, and that's always where things break down and go wrong, I suppose. 14:27
92 Q. Nicola, when did he start displaying those challenging behaviours? 14:28
A. Well from a young age he always was challenging, but they were manageable. You were able to -- well, us as a family we were always able to maybe talk him round or -- he was a very sociable person too. Like he -- any time we would have went, as I say there, if we'd have went down the town and maybe met staff or ones from different areas of the Abbey Hospital, he was always talking to them, you know, and they were speaking to him and were very -- you know even in, times when we had him in the Cosy Corner, that if staff had of come in he was always -- you know, he would have always run up to shake your hand, or say hello or whatever, you know. So he was always very happy there. There was always very -- there was never any worries about him not wanting to be there. 14:28 14:28 14:28
93 Q. And he spent a significant period of time there overall?
A. Yes. He was there from he was around aged 10, yeah.

94 Q. Yeah.
A. In and out.
95 Q. And in your statement you described him coming in and out on four different admissions, and by my calculations, totting it up, he was there in total for around 18 years at Muckamore Abbey Hospital, is that about right? 14:29
A. That would sound about right, yeah.
96 Q. Yeah. Would you have visited him regularly there over his stays? 14:29
A. Not so much visited him. He would have -- whenever we went up he obviously come home with us. So we would have been going in -- well it was mainly my mum would have been going up to pick him up to bring him home for his home stay home at the weekends. He would have always come home on a Friday, and went back in on a Sunday. Any time I would have been going it was mainly just to pick him up. That was if mum was on holidays or, you know, wasn't able to maybe get to see him or whatever. But I would have just been picking him up and then taking him back in the same evening. He never would have stayed at home with me, you know, but definitely at home with mummy he would have always stayed. 14:29 14:29
97 Q. Would you have spent much time in the hospital then? 14:30
A. Not overly, no. It would have just been to pick him up and drop him back in again.
98 Q. And then bring him home.
A. A few occasions when he was -- he wasn't allowed home,

we would have collected him and went across to the Cosy Corner. But a few times when my mum would have been going in she would have been able to go in and go into like a separate, like a visitors' room, when he wasn't allowed out. But I, I didn't, I wouldn't have been in that room as such. 14:30

99 Q. Is it fair to say that the family was happy generally with the care he received the whole time he was in Muckamore?

A. Yes. Yes. Uh-huh. Uh-huh. 14:30

100 Q. And you described him being able to do activities that he enjoyed at Muckamore.

A. Yes.

101 Q. What sort of activities?

A. He went to day care every day, and that was a usual routine. Every day there would have been something different. It was either baking, going to -- they maybe went to Tesco for a day to get the ingredients or whatever they were, you know, going to be using, to the Loch down to see the ducks, feed the ducks and that. 14:30 14:31 Horse riding. Swimming. You know there was always a routine to it, and he was, he was always keen to be going to them and doing them. A lot of these other place didn't do that with him. You know, they didn't do -- they wouldn't take him places, or they didn't take him places, or he wasn't able to go places because he was so destructive, you know, but while he was at the Abbey he was more than keen to do all these things, and happy to go. He loved the horse riding. That was 14:31

one of his main outings, you know, that he looked forward to.

102 Q. And whenever you refer to his most recent placement at Muckamore, which I think was 2007 to 2018, whenever you were describing that period in your statement you said that he generally appeared to be happy? 14:32

A. Yes.

103 Q. What made you think that he was happy at Muckamore?

A. Just because he was -- as I say, any time you went in, he would have been running -- well, he was always keen to get out, to come home. He was happy to come home. But he was always happy to go back again. There was never any issue of him going back in. As I say, if we had of had him down the town maybe over that weekend and he would have met somebody, he'd have been shaking their hand or, you know, giving them a hug. That was certain -- just different staff members that maybe you would have met, or friends of mine or anybody, you know. Like he was always happy. There was never any issues or any physical -- physical marks or bruising or anything that would have caused concerns at all. 14:32 14:32

104 Q. Yeah. Whenever you are talking about that in your statement, you referred to one incident where Greg had hurt his elbow, isn't that right?

A. He had a sore elbow, yes. 14:33

105 Q. That's the only incident that your family can remember that he was injured at his time in Muckamore?

A. Well, yes, as far as I'm aware of. Now he had come home and his elbow was sore and swollen, and he had --

obviously mum had noticed it -- and he had said he had fell out of bed, but when Mum was taking him back again then she had mentioned it to the staff and they had said that they weren't aware of him falling out of the bed, but they were aware that his elbow had been sore, 14:33
but they, they hadn't contacted mum to say about the elbow, you know before. The first mum knew about it was when she had seen it herself when he had come home.

106 Q. And did the staff giving any explanation?

A. They did. Gave a medical name for it. Now I don't know what that was or what -- you know, it did, it just was full of fluid and swollen. But it did disperse. I don't know whether he was on medication or got medication for it, but it did heal. 14:33

107 Q. Can you remember when that took place? 14:34

A. I can't remember.

108 Q. He was in...(INTERJECTION)?

A. Within the last few years of his stay in. But to a specific date or time, no.

109 Q. Yeah. Is it right that he was in Cranfield Ward at the time, I think you said in your statement. 14:34

A. Cranfield, yes. Yes. That was his last -- he was -- it was Cranfield he was in the last period of time that he was in the Abbey, yeah.

110 Q. And who was it that said he had fallen out of bed on that occasion? 14:34

A. Gregory himself to mum.

111 Q. He himself.

A. But that would have been, you know, a general thing for

Gregory to say, just to get carrying on doing whatever he was doing, you know. He didn't like fuss, you know touching around him or you know feeling him, you know touching him or anything. He wouldn't have -- he just wanted to sit. When he was home he would have sat in 14:34
the kitchen and watched DVDs on the TV. Everything had to be in its place. If that was disrupted at all it was, you know -- the like of a control for the TV, if I had lifted it to turn it down, or mum had of lifted it to turn it down, it would have -- and set it 14:35
somewhere else, it had to go back to the specific place where it had been, you know. Everything had to be in its place. The CDs as well, they had to be set -- or his DVDs, whatever he was watching, you know it had to be specific where he wanted it to be. 14:35

112 Q. Just right. Yeah. But aside from that one incident then there were no other concerns at Muckamore?

A. Not anything that caused alarm. Obviously he had his moments when he maybe was kicking off, but there was never any marks or anything that would have caused 14:35
alarm or caused us to feel that we needed to report anything or question anything. He was generally happy there and seemed happy there.

113 Q. One thing that you do say that your family had concerns about was the resettlement process from Muckamore? 14:35

A. Yes.

114 Q. Is that right? And you described Gregory being in and out of Muckamore.

A. Yes.

115 Q. Each time you said he had a community placement, you described it as being unsuccessful?

A. It just never worked for him and it just wasn't -- he just couldn't seem to cope with the choice and the freedom of being in a situation or a setting like that, you know like the freedom of choice and his own to come and go as he pleased -- not to come and go out of the place, but in the building. It just never seemed to work. 14:36

116 Q. Was your family consulted before he moved to those placements? 14:36

A. Oh, yes. There would have been meetings. It was always discussed. Like there was a few times places were suggested and we just -- Mum would have said no, they were either too far away or we just -- I think that's why we always thought he was -- well, we knew he was happy in the Abbey, but these places never worked out for short-term periods over maybe four, five, six months, it always broke down. Whereas when he was in the Abbey it was always for longer periods of time and it just seemed to be that was his home. That's where he felt happy. That's where he -- whether it was down to structure or the fact that there was nurses in uniforms and that seemed to -- whether he got a safety thing from that or what, I don't know. But the length of period of time that he was in the Abbey always were far happier and he seemed to be more content and happy than any of the places out in the community, the settlement places. They never -- they just didn't work 14:36 14:37 14:37

for him.

117 Q. You mentioned there on some occasions your Mum would have said that a place was too far away or would have objected, I think is how you put it in your statement.

A. Mmm. 14:37

118 Q. How were those objections received? Were they taken into account?

A. Well personally I can't -- because I wasn't at the meetings or wasn't there. But I know that he didn't go to them. He wouldn't have, you know -- they would have 14:38 said, 'okay, we'll leave it now' or, you know, that he wasn't made to leave then. Then it maybe would have been another six months or however long and then somewhere else would have been suggested. Now I think there was only two, two particular times that we said 14:38 no, that it wouldn't work, and they were either too far away or Mum would have maybe went and visited -- or not visited them, but drove down to see where they were, and it was either not suitable for her to get to or -- but we knew that they wouldn't -- it wouldn't work with 14:38 Gregory anyway, because it just -- it just -- it had been tried so many times and it just broke down every time due to his behaviour and the staff not being able to deal -- you know, to cope with him, to cope with managing his behaviours. 14:39

119 Q. He last left Muckamore in 2018, isn't that right?

A. Uh-huh.

120 Q. In your statement you describe a difficult period of ill-health for Gregory. How is he doing now?

A. Well he had another bought. He was in hospital there last week, and again with this haematoma in his leg, but he's back into the home that he is in at the moment now and it is healing, it is dispersing. But, again, his behaviour is quite disruptive at the minute. It seems to be that when he is in pain or physically not well, this is how he puts himself across. He just doesn't want anybody near him. He just won't accept the nurse -- you know, nurses or doctors or whatever working with him and helping him. Whether it is not just down to understanding that he is ill and he needs to get this help, I don't know. But at the minute he is still a bit destructive. He was throwing himself out of his wheelchair and stuff this morning. But the leg itself, it is healing. 14:39 14:39 14:40

121 Q. You provided with your statement two photos of Greg that you wanted the Panel to see, which they have. Can you tell them a bit more about the photographs? About where they were taken?

A. Well the first one is Gregory while he was in the Abbey, happy and content. (Upset and crying). And, as you can see, the second one was when he left hospital in April 2020 and went into the facility that he's in now, and he's just a shadow of himself. Yes, he wasn't well and he was physically unwell, but he was also very mentally unwell too. And just the facility that he was in at that time weren't able to manage him and cope with him. Yes, COVID played a big part there too because nobody was allowed in, or places weren't 14:40 14:40

getting -- patients weren't maybe getting seen as quick as what they should have been. We weren't allowed to get into the facility either to see him. So mentally his health wasn't good. He just wasn't in a good place at all. 14:41

CHAIRMAN: Can I just ask? The timing between the two photographs. The first photograph was when he was in MAH.

A. There is probably -- I think the first photograph is probably around 2016/2017, and then the last one there is 2020, when he first went -- because we weren't able to get in to the new facility, even into the nursing home, they were obviously doing video calls and sending us pictures, and that was the first one that... 14:41

CHAIRMAN: Oh, I see. So how long had he been there? 14:42

A. He had only been there a few days when that second photograph was taken, because that was, obviously, how they were communicating to us over the telephone and then sending us photographs of him.

CHAIRMAN: So the loss of weight occurred where? 14:42

A. The loss of weight occurred just over the period of time. His loss of weight would have started when he was unwell in 2019 from his admission to...

CHAIRMAN: The next place.

A. I don't know whether I can say the hospital. 14:42

122 Q. MS. KILEY: The supported -- the hospital facility.

A. No, the hospital.

123 Q. Yes. From Lakeview.

A. Yes. Uh-huh.

124 Q. We did name that hospital, yes.
A. So his deterioration, and his weight, and his mental health just over that period of time was significant.
125 Q. And following -- that was the period of time where you have described admissions in and out of Antrim Hospital for other...(INTERJECTION)? 14:43
A. Yes, and again that was down to COVID as well. I think just there was -- just everybody was finding it hard to get seen, you know.
126 Q. So the photograph, that second photograph would have been taken then just shortly after he was discharged from Antrim Hospital? 14:43
A. Yes. Uh-huh. A few day.
127 Q. In April 2020.
A. Yeah. Uh-huh. 14:43
128 Q. Okay.
A. When he first arrived in the home that he is in now.
MS. KILEY: Nicola, I have no other questions for you. The Panel may have some, if you want to wait. But thank you. 14:43
A. Okay. Thank you.

END OF DIRECT EXAMINATION

CHAIRMAN: No, I don't think we do. 14:43

Nicola, can I just thank you very much for coming along. I know how difficult this was for you, but you've got through it and I hope you're feeling better

now. So thank you very much for coming and telling us all about Greg, which has been very useful.

A. Okay.

CHAIRMAN: So thank you very much.

A. Thank you. 14:44

CHAIRMAN: All right. Okay. If you'd like to go with Jaclyn.

A. Okay.

THE WITNESS THEN WITHDREW 14:44

MS. KILEY: Chair, that ends this afternoon's business. We recommence tomorrow at 10:00 a.m. tomorrow with a live witness who hopefully will give evidence in this chamber and that is a father of a former patient. 14:44

CHAIRMAN: Yeah. I think Mr. Doran is calling that witness.

MR. KILEY: That's right.

CHAIRMAN: He may be quite lengthy, but we'll see where we go. 14:44

129 Q. Yes.

CHAIRMAN: All right. Well thank you very much indeed.

MS. KILEY: Thank you, Chair.

CHAIRMAN: Okay. That concludes our business for today. Thank you very much, indeed. Thank you. 14:44

THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 6TH JULY 2022 AT 10:00 A.M.