MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY 14TH SEPTEMBER 2023 - DAY 57

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

GWEN MALONE STENOGRAPHY SERVICES

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THE HEARING COMMENCED AT 10:00 A.M. ON THURSDAY, 14TH SEPTEMBER 2023 AS FOLLOWS:

CHAIRPERSON: Right. Ms. Tang.

MS. TANG: Good morning, Chair and Panel members. 10:01
This morning I will be reading five statements into the record. They are from the following witnesses: P100's mother, P99's nephew, P104 and P105's mother, and finally P98's mother. I can say, Chair, that there will be an application for a Restriction Order in 10:01
respect of P98's mother's evidence. What I propose to do, therefore, is to read the other four statements first and then take a break.

CHAIRPERSON: Yes. Okay.

MS. TANG: I'll make the application after the break 10:02
in that case, Chair, and I will ask that the application itself be made subject to restrictions.

CHAIRPERSON: Yes. Having read it, I can readily see why a Restriction Order may be necessary.

MS. TANG: Thank you, Chair. The first statement I am 10:02
going to read relates to P100's mother. The internal page number is STM-121 -- 1the statement is dated the 5th day of June 2023.

"I, P100's mother, make the following statement for the 10:02
purpose of the Muckamore Abbey Hospital Inquiry.
My connection with MAH is my son, P100, is a patient at MAH. The relevant time period I can speak about is between 1987 and the present date.

I am a farmer's daughter and a farmer's wife. My husband", name is redacted, "P100's father and I have three children". The name of P100's sister is redacted, date the birth is given as 30th April 1966. P100's brother name is redacted; date of birth as 15th July 1967, and P100's date of birth is redacted and given as 1st of April 1969. 10:03

"When P100 was born, his sister was two years and 11 months old and his brother was one year and nine months old. P100 was born at the Hardy Greer Maternity Hospital in Downpatrick. His delivery was described as normal by the hospital staff. I thought he was very pale and my brother-in-law", whose name is redacted, "said the same. 10:03

P100 was a very cross baby and did not sleep during his first year. I thought he was possibly deaf and dumb. However, we subsequently found out that due to a lack of oxygen when he was being delivered, he sustained brain damage. He was around eight months old when we were told this. 10:04

I told the health visitor at the time about my concerns but was told that P100 was just a cross baby. I took P100 to Castlewellan for a hearing test. He could not hear anything to enable the hearing test to take place. We were referred for further hospital tests. These were not for his benefit but for the benefit of others 10:04

and for a medical understanding of his condition, I was told at this time by the health visitor. In those days, you ask not get much information as a parent on medical matters.

10:04

In terms of P100's development, as he got older we realised that P100 was not deaf as he would jump at loud noises, for example when a door slammed. P100 started to walk when he was around one year and five months old. P100's speech was slurred. He was 10:05 teething very early and had some teeth from just three months old.

As a small child, P100 loved cycling. He was very clever and used to stop the bike using his toes as 10:05 brakes. He loved playing with toys and had a favourite spinning top. From around the age of five, P100 went into Downpatrick Special Care Centre in Downpatrick. He was there for between one and two years but they could not deal with his behaviour. 10:05

When P100 was about six years old, he moved to another facility" which name is redacted. "I thought that P100 got on well enough there in that he got the support he needed and he was content there. He stayed at that 10:05 facility until he was 18 years old. We visited him approximately every fortnight and P100 would come home for around 14 weeks per year. These visits would take place at set times, like around Christmas and summer

time.

I recall one particular incident at that school, I think P100 was around 12 years old at the time. Someone pulled at his chest around the breast area. I recall seeing five red marks from the person's fingertips. Other than this, overall I thought that P100 was safe there with the family", I won't read the name of the family, "a husband and wife team and the other staff. 10:06

P100 did not really take to, as in like, to be in the company of very many people and he liked to keep himself to himself. He was diagnosed as having brain damage and autism, and needed constant attention when he was at home and when he was in school or in public. I'm not sure when he was diagnosed as having brain damage and autism but I think this was when the doctors ruled out deafness. It was before he was six years old. 10:06

P100 wore nappies until he was 15 years old and would have wet the bed at home. We had to bath him as he could not do this on his own. P100 does not like being bathed, I have to bribe him, and it is hard to get him to do anything that he does not want do. 10:07

P100 was always wanting to go out so we kept the doors locked. We taught P100 to feed himself and he was able

to do this from when he was around two or three years old. We would initially have had to cut up his food now, P100 can eat on his own but he tends to eat too fast. I have to have the dinner ready for him coming home and as soon as he is in the door, he will want to eat. 10:07

P100 was only allowed to stay in the school until he was 18 years old. Our social worker advised us that MAH was the only option for P100 thereafter. P100 was placed in MAH for a period of time. I cannot recall the length of time P100 was in MAH or when he was admitted or discharged. I do recall that after some time, P100 was moved to a facility for autistic people in that facility", again the name redacted, "called", again the name is redacted. "I cannot recall the names or the dates or the name of the facility but I do recall he was only there for a few weeks. I felt that it was not properly staffed and only employed social workers and university students. I was contacted by a member of staff at the facility who advised us that they could not care for P100. I do not recall the name of that member of staff. 10:07 10:08 10:08

In addition, the person told me that the facility had contacted the police, who had attended and put P100 in handcuffs and taken him to MAH. I do not believe the police should have used handcuffs on P100 as he was a vulnerable child. I recall that this was extremely 10:08

upsetting to me. I recall hearing about a patient who choked and died there, and I heard that there was a police investigation.

P100 was placed in MAH when he was 18 years old in around 1987. My father's cousin", whose name is redacted, "was one of the first nurses in MAH and little did I know I would have a son in there. P100 settled well in MAH. We were told by the MAH staff that he was doing all right. I do not recall what ward he was on or the staff who dealt with P100 or that I spoke to. We would visit him regularly and take him out of MAH for meals. I do not recall any issues taking P100 out of MAH. 10:08 10:09

P100 loves getting home. He would normally have home visits every two to three weeks and stays for a couple of days. He loves being at home and settles well. He enjoys getting out on his bicycle. I recall one occasion, although I'm not sure when this was, when I was returning P100 to MAH after he had been home for a few days. When I drove into the grounds, P100 started to cry and had tears running down his face. I do not recall any further details about this incident. 10:09 10:09

We never got to see any of P100's bedrooms in MAH but I think that it was a dormitory arrangement with cubicles for each person. I do not recall how I found out this information. When I visited, I found MAH to be fairly 10:10

clean although I was only ever in the dining room as this was where our visits normally took place. I do not recall why the visits took place in the dining room. I found the staff there to be nice. I actually thought they were all nice because of their manner and from speaking to them during visits. I do not recall any of the names of the staff.

When P100 was in MAH, he was moved about between different wards. He moved between Movilla A, Foye beag, Erne and Killead. I cannot recall the dates. I remember on one occasion when P100 was moved, we were not told and neither was P100. He was just moved one night without any prior communication. I felt that MAH moving P100 without telling me was unprofessional. I recall feeling devastated and angry that this could not have been communicated to me in advance. I was also upset that P100 had to be moved at night rather than during the day. He had his own space in MAH. He had a bed with a cubicle around it, his own sofa, his own television and a table for him to eat at. I hated P100 being in this room because of the lack of space and that it was not home.

I recall when I was visiting MAH to take P100 home for a few days, he would see me from the windows he would fly like a wild bird to get out to me. He would run quickly to the top of the stairs but he would have to wait for a member of staff to unlock the door and let

him out. I recall P100 having to be moved due to an electrical failure in one of the buildings.

P100 is currently a patient in the Killead Ward and is quite happy there. P100 was moved to the Killead Ward around two years ago from the Erne Ward. I was advised by a Staff Nurse that the Erne Ward was closing down. I feel that in both Erne and Killead Wards, P100 is isolated. They are both wards in the old building and I do not think either are appropriate for P100. He is not able to be around other patients, and this is important for him as he likes to be around people and to have some company. 10:12 10:12

P100 apparently requires more medication to deal with the behaviour of the others in the ward. I do not like P100 getting more medication. I raised my concerns recently with a member of staff" whose name is redacted H443 cipher, "one of the staff nurses involved in P100's care, but she advised me that it would not be safe to have P100 and the other patients in communal areas at the same time. 10:12 10:12

H443 is one of the nurses who is now cares for P100. She has been his nurse for the past two or three years and he loves her, and I think she is a good nurse. H443 communicates well with me and regularly updates me when we talk on the telephone between visits about how P100 is, which I really appreciate. 10:13

However, there have been a few incidents that I would like to bring to the attention of the Inquiry. I recall one incident in 2017 or 2018 when I had booked a holiday for myself. While I was getting ready to go on holiday, I was contacted by someone from MAH, whose name I do not recall, to say that P100 was unwell. When I went up to MAH, I found that P100 was in a lot of pain and could not stand. I watched P100 and I realised he was constipated. I took him to the en suite and I was right. The only issue that he had a very hard stool and he was badly constipated. I was surprised that I had to diagnose this. I remember a doctor being called because P100 was in so much pain and was lying on the floor. I do not think it should have gone that far. P100 was given some medication and he remains on it from then. In the end, I did not go on holiday and I went to visit P100 every day instead. 10:13 10:13 10:14

More recently, there has been a very high proportion of agency workers. Up to around 70% of the staff at MAH can be agency staff. I have noticed this increase from around 2020, and I feel that the increased use of agency staff means that care standards are falling, and I am worried about this as I feel that agency staff do not know P100 well enough to care for him. I feel that care standards are falling because P100 is not being cared for by staff who know him and who know his needs. 10:14 10:14

There was a safeguarding incident around March or April

2022 when P100 was being cared for by agency staff. Their names were not disclosed to me and I was told the reason for this was that there was still an ongoing safeguarding investigation. I was told about this safeguarding investigation by an investigating officer from the Adult Safeguarding Team but I do not recall their name.

Sometimes P100 does not sleep. I found out that the staff had not really tried to help him. The help that I feel P100 needs is things like being treated with care and patience. They had not given him anything to drink. The staff on duty were on their computers and would not let him use the computers. P100 emptied the pencils all over the place. I do not recall who told me about these incidents.

When P100 is agitated, he now rips his clothes. I believe this is due to his treatment and experience at MAH and I am concerned about this. If P100 is with staff that he likes and who he knows and if the staff know him well enough, then I do not believe these behaviours would be as bad. I feel this is P100 seeking attention. I am therefore concerned that the staff are not providing P100 with the one-to-one support that they should be. I do recall speaking to a member of staff on the phone about this, but I do not recall their name or when this was. I do not remember the staff providing me with an acceptable reason as to

why P100 would do this. I recall times when P100 would say things to me such as "I'll hit you a slap" or "I'll kick your bloody arse". P100 began to curse a lot. P100 would not have said these words before he went into MAH and would not say these words at home. I feel P100 has heard these words in MAH and then he would repeat it. I do not hear P100 say these as much now but he would have said them a lot a number of years ago. I worry that P100 was not doing what he was told or what staff wanted him to do, and so staff members would have said these things to him. 10:16 10:16

I recall one occasion, although I am not sure of the date, when P100 came home and I noticed a large scar on his head. The scar was on the top of his head near his crown. I have no idea how P100 sustained this injury. P100 only wore his hair long for a short period and I believe he sustained this injury during the time when his hair was longer. I wrote a letter of complaint to MAH but I did not feel that I received a satisfactory response from them. It seemed to me that nobody knew anything about this. I believe this would have been a significant injury and I feel that I should have been telephoned right away. I wonder whether this is part of a cover-up and whether MAH staff thought that I would not have noticed. I am not sure what ward P100 was on when this happened. I attach copies of correspondence as exhibits 1, 2, 3, 4, 5 and 6. 10:17 10:17

I recall one occasion in 1999, although I cannot remember the exact date, when I saw black and blue marks on P100's body around his legs area, as well as friction burns. He had friction burns on his legs and had angry red skin. I wrote a letter of complaint as I did not understand how he would get these injuries. MAH responded to say that P100 did it to himself. I attach copies of these letters as exhibit 7, 8, and 9. 10:18

I recall going to MAH for an open day; I cannot recall the date. This open day was attended by the parents and families of patients, and there was a band and dogs. The open day was organised by MAH and I am not sure why it was organised. When I arrived, I was shocked to find that P100 was wearing a pair of trousers which had a broken zip. P100's privates were visible, and the soles of P100's shoes were hanging off. When I found P100 like this, I was devastated, I always provided P100 with new and clean clothes. P100 always would have had around 20 pairs of trousers in his wardrobe, which is why I could not understand why staff would have put faulty trousers on P100. I feel staff could not be bothered to change P100. I had to pull his coat down as far as I could so that it covered the zip area. I did this to respect P100's dignity. 10:18 10:19 10:19

As a result of seeing this and feeling this way, I spoke to a member of staff about this but I do not recall their name. P100 was then dressed properly.

P100 was not used to getting medication before going into MAH. Before going into MAH, P100 was not prescribed any medication. I was told by the social worker that when P100 goes into MAH, he would not be given any medication at all. I do not recall the name of the social worker or when they said this. Now, P100 is stuffed with medication. I mean that I believe he is overmedicated. 10:19

Last summer, P100's brother and sister-in-law took P100 to the beach. P100's presentation was very subdued. P100's brother was very concerned. P100 sister-in-law is a nurse and felt that something was not right so she raised her concerns with a member of MAH staff", the name is redacted, "H444. We cannot recall her surname. H444 had come to collect P100 and she contacted the ward to allow P100's sister-in-law to speak to the nurse in charge. I do not recall who the nurse in charge was at that point. The impact on P100 is that he can present as being very drowsy and he can barely speak at times. This incident and the concerns reported by my daughter-in-law led to the discovery by MAH staff that he had been administered a double dose of his medication. The nurse in charge advised that P100 had been given his prescribed dose before he left the ward. However, H444 did not know that P100 had received his medication and gave him his prescribed dose, meaning that he had twice the prescribed amount 10:20 10:20 10:21

of this medication. I was told by a member of staff that it was a genuine accident. I do not recall the staff members dealing with this or the name of the medication. My daughter-in-law telephoned the ward to complain that he had been overmedicated due to a lack of communication when P100 was taken out for a visit. I can also recall, for around a month in 2021 or 2022, P100 had been receiving his medication twice. 10:21

I recall one occasion when I was visiting P100 that I found out that he had had an epileptic fit. I did not witness it but I could tell that P100 was a bit dopey during my visit. P100 mouth was down on one side and he was walking more on one side and limping. I thought that P100 had had a stroke. When I saw P100 like this, I felt so worried so I spoke to the staff on the ward. I do not recall what ward P100 was on when this happened. I do not recall who I spoke to. I was told by a member of staff that P100 had had an epileptic fit and that they had provided P100 with epilepsy medication. I recall asking the nurse if P100 would have to take this medication permanently and I was told that he would have to be on this medication for some time. I was also told that this medication would help P100 with his mood. P100 does not have epilepsy but he is given epilepsy medication in case of a recurrence. 10:21 10:22 10:22 10:22

P100 was not allowed home for approximately one year due to Covid restrictions. I was told this was because

of the Covid regulations. I was also not allowed to visit P100 at MAH for approximately one year. I found it very difficult not seeing P100. After around a year, I was able to start visiting again although there are new visiting dates and times. I visit about twice per month. We now have visits in the library and we had a picnic on a number of occasions. We have our visits in the library because of the Covid precautions. 10:23

In May 2022, P100 was finally allowed home for a visit to our house" and the address is restricted. "He was brought down in a bus by two MAH staff members. It is a long journey for P100, around 40 miles. We had a very good Sunday visit. We took P100 out and he asked to go back again to our house. He initially seemed afraid of the bus, but we gave him coffee and ice cream and he jumped up and got onto the bus. 10:23

I feel that MAH is a good place but the staff levels are much diminished over the past two to three years with a lot of staff leaving. All the staff I was familiar with such as H435, H436, H437, H438 and H439, who worked on various wards and who were all staff nurses and, apart from H435, have now left. I understand that H435 is still employed by MAH but he is suspended. I do not know some of these staff members' surnames. I would not be familiar with many other staff members as they are all usually agency staff. 10:24 10:24

Since 2021, I have had H440 as my carer's advocates. H64 was P100's social worker in MAH. Since she retired in around summer 2022, P100 has not had a social worker. H84, who was P100's social worker, was super; she was very helpful. H441 was P100's community social worker but left her post just before Covid and we have only just been allocated a replacement, H442.

The television is very important for P100 as he loves watching television, particularly the news. P100 needs a box for the television as it has been broken. I recall a time when I visited P100 at MAH and I noticed his television was smashed. I asked a member of staff, whose name I do not recall, what had happened. The member of staff advised me that the screen was cracked after P100 had punched it. I remember at the time looking at P100's hands and neither were marked or injured. This damage happened when P100 was in the old building prior to him being moved to the Erne Ward.

The impact of P100 having neither an MAH social worker, nor a community social worker, was that there was a lack of communication between me and the various parties, and that P100 was not being visited in MAH. Without a social worker providing me with updates, I was left to try and find everything out for myself. It was not until I was assigned a carer's advocate, H440, that these issues were raised with MAH. And H443, one of the nurses, started providing me with regular

updates.

I do not see the staff very much when I visit. However I know that P100 has his favourite nursing assistants. He likes H444, H443 and H437. The reason I feel P100 likes them is because they seem to do a lot for him. They take him out for walks. I can see from how P100 reacts to each of them that he likes them and he feels safe. 10:26

In the past, I do not recall MAH telephoning to notify us of any of these incidents. However, in the last year or two I now receive telephone calls all the time. For example, when P100 is nipped, I get a phone call. P100 has been nipped by other patients and has sustained bruising and skid marks on his knees and elbows. These injuries healed on their own without treatment. I recall him having sore toes as well. 10:27

P100 has his needs and I would like MAH to deal with those appropriately. When P100 is at home, he has a rubber sheet. P100 has normal adult needs and he uses these rubber sheets to masturbate in the privacy of his room. He goes into his bedroom with it and is in far better form afterwards. I do not know if they do in MAH but would I like the staff to facilitate this. I think this would help him because it is very normal and his needs should be respected. 10:27

P100 is now in Killead Ward and he has his own pod. I also know that P100 is not allowed into the communal area with the other patients. I recall speaking to H443 about this and she told me that P100 and the other patients could be at risk if this were allowed to happen. It upsets me that P100 is being restricted and that he is spends so much time on his own but I understand the reasons why. 10:27

I think that MAH has allowed P100's weight to increase. I think that he should only be around 16 stone but he is now around 17 or 18 stone. I believe that P100 should lose about three or four stone as I think he would be less boisterous. I am concerned about P100's weight gain because he already finds it hard to walk. It would be better for his heart, in my opinion, if he were to lose weight. P100 has been diagnosed as having high cholesterol and he now has to take medication for this. I do not recall when he was diagnosed with this condition. 10:28 10:28

P100's activity levels are affected by his mobility. He is not great on his feet. We take him in the car and go for a short walk, and then he wants to leave. I think that P100 gets very little exercise. He used to go swimming once per week, and he does not like to walk. P100 has never liked to walk. P100 is not as fit as he used to be. I know that P100 is now 53 years old but he should still be a lot fitter than this. 10:28

We were offered resettlement for P100 to a place at", the name is redacted. "We went to visit there but we were not impressed with the size of it. I did not feel that there was much space and I also felt that the facility was staffed with a lot of unqualified staff and did not have enough qualified nursing staff. Unqualified staff would not have the same knowledge and skills as qualified nurses. On a number of occasions, the facility staff went to MAH to meet with P100 there. This did not go well and I would judge it to be a flop. This is because the facility did not have the facilities they claimed they did and that P100 needed, and the resettlement did not go ahead. 10:29 10:29

I remember telling staff in MAH that P100's living area in that facility was very small and I felt that he needed more space. P100 did not even get to visit the facility", whose name is redacted, "and I consider the process of resettlement to have been like trying to fit a square peg into a round hole. I feel that they were trying to put him into a box and I do not think that they used a person-centered approach. I attach copies of my letters of complaint and the responses to this statement as exhibits 10, 11, 12, 13, 14, 15 and 16. 10:30 10:30

We were also offered a resettlement for P100 to a place in Mallusk. I do not recall the name of this facility but it was just outside Belfast. This is the same

distance away for us as MAH. P100 nearly went to this place at Mallusk which was then in the process of being built. The facility of Mallusk consisted of a small number of houses; I think that these were previously religious houses. This facility did not have any staff 10:30
and some of the buildings needed renovated. This proposal was being discussed around March 2020 at the beginning of the Covid pandemic. I recall having telephone conversations with H441, a social worker, who I felt was very good and she recommended this facility. 10:31
I also had a telephone conversation with a person who I think was H441's boss, and they also suggested this. I cannot recall their name. I did not want P100 to go to Mallusk because I felt this was too far from home. As I am getting older, this would limit how often would I 10:31
get to see P100 and I wanted P100 closer to his brother and sister so that they could visit him and he could have more of a family life.

Over a number of years, there have been several 10:31
unsuccessful attempts at resettlement. As I have mentioned, I feel that each one was hampered by poor planning and none of them, as I mentioned previously, were as person-centered as they should have been. I felt that I was under pressure by MAH staff to agree to 10:31
resettlements, with the risk being that if I rejected any resettlements, P100 would have ended up in the Bluestone Unit, which was part of Craigavon Area Hospital in Craigavon. This is a facility for people

who are ill and with a learning disability. It is far from home and not accessible. I felt this was blackmail and I felt powerless as a parent.

I feel that I want the best for P100 but it is only because I think P100 has the same rights as the rest of us. I feel very strongly that P100 should be treated with dignity, respect, care and compassion. He should have the level of care that would be afforded to any of the rest of us. In summary, the resettlement process has not been centered on P100's needs and has not taken into account P100 and our family experience. 10:32 10:32

There has not been any discussion of resettlement since March 2020. I think that P100 is all right in MAH. Overall, I am consent with MAH. However, I think that there needs to be more nursing staff and better trained staff. 10:32

P100 does not like doctors or going to other hospitals. I recall one visit to our general practitioner when P100 was about five or six years old. P100 was doing something and another patient who was in to see the doctor slapped him and asked him if his mother ever did that to him. The suggestion was that I was soft on him. I feel that nobody understands how difficult it is for us. 10:33 10:33

More recently, for example, P100 was brought to", a facility whose name was redacted, "for his Covid

vaccination. He had to be accompanied by three or four nurses. I think it was very difficult for P100, and the staff had to come out to the bus to see him. H435, who is a staff nurse talked to P100 and managed to vaccinate P100. P100 did not even realise that he had 10:33
received the vaccination.

He also finds the dentist very traumatic as he once had seven teeth removed in one day in around 2001. This happened while he was at MAH. I am not sure of the 10:34
reason why P100's teeth were taken out and we were not told in advance. The reason that P100 found this traumatic is because it would have been very painful and uncomfortable.

10:34

I attach some photographs of P100 as exhibit 17."

The witness goes on to say that she has a number of things she would like the Inquiry to achieve. She would like to get to the truth about the scar on P100's 10:34
head, and she would like staff to be prosecuted if they have done something wrong.

"It seems to me that a lot has been covered up. I would like improved practice in standards of care so 10:34
patients can be properly looked after. I wish for P100 and all those patients who remain at MAH to be resettled closer to their families. I hope that fully trained and experienced staff will be working with P100

in the future when he is resettled. I wish for P100 to have a better quality of life so that he is treated just the rest of us and he is not treated any differently than others. I feel that there needs to be a shift in the culture of the organisation to one which honours openness and honesty. I think that there should be a duty of candour on staff at MAH. I think this needs to exist in whatever environment P100 lives, whether that is MAH or not. I feel that staff need to have a stronger value base and need to strive to do the best for those they care for. To this end, I feel that selection and recruitment of staff with these qualities is key." 10:35 10:35 10:35

The witness then goes on to confirm her wish to give evidence. There is a list of the exhibits that the witness has provided with her statement, which is on page 17. I don't propose to read through all of these but just to draw your attention that these relate to the complaints and the various investigations that the witness referred to in her statement. 10:35

CHAIRPERSON: Yes.

MS. TANG: Chair and Panel, the next statement that I am going to read into evidence is that of P99's nephew.

CHAIRPERSON: Sorry, hold on, were you to bring our attention to any part of the complaints or you just wanted to -- 10:36

MS. TANG: No, Chair, I wasn't proposing to do that I felt that the issues raised in the complaints have been

dealt with in the statement.
CHAIRPERSON: All right. Okay. The Panel will look through those in due course if they haven't read them already. I expect they have. Yes, okay. So, we are on to 99? 10:36
MS. TANG: P99's nephew is the next statement, Chair. The internal page reference for that is STM-134-1. The statement is dated 24th August 2023.

"I, P99's nephew, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. My connection with MAH is that I am the nephew of P99 who was a patient of MAH from 1950 to 2018. The relevant time period I can speak about is 1950 to 2018. 10:37

I am the nephew of P99. P99 was a patient of MAH from 1950 to 2018. She died on 2nd January 2020. I attached at exhibit 1 a photograph of P99.

P99 was the youngest of 22 children, three of whom died at birth. Many of her siblings are now deceased. P99 has a sister" whose name is redacted "who is living in America, and her brother and my mother who both live in Belfast. 10:37

My mother, P99's sister, acted as P99's next of kin throughout her time at MAH and she represented P99's interest in trying to get a public inquiry into MAH, and commenting to the Minister of Health on the 10:38

proposed terms of reference for the Inquiry.

To the best of my knowledge, P99 was born with brain development issues. In those days, hospitals did not routinely carry out tests to find out the cause. You were given a general prognosis and told what care was likely to be required. I understand shortly after birth, a consultant in the Royal Victoria hospital had informed my grandmother that P99's needs would become so severe and complex that he did not think they would be able to cope, given where they lived. The same consultant advised that P99 would have a very short life expectancy and was unlikely to life more than 13 years. The level of special care required would be considerable and that, given the tough economic times, P99's mother felt that her other children may be at risk. 10:38 10:38 10:39

My grandparents were subsequently advised by the treating consultant of a place called Muckamore Abbey Hospital, which had just opened and was state of the art for the island of Ireland. My grandparents had never heard of Muckamore Abbey Hospital but they trusted a figure in authority. 10:39

At aged two years, P99 had reached little or no developmental milestones. Although I cannot recall the exact date of diagnosis, P99 also developed epilepsy and was readmitted to MAH in 1950 when she was two 10:39

years old. MAH was about 25 miles away from the family home with no access to a car, so our family relied on a bus to visit P99.

I remember visiting P99 in the 1980s. I would have visited with my mother or sometimes my sister, P99's sister", name is redacted, "about once every three months. We would bring her food and sometimes cooked meats. I recall that these had to be given to the nurses who would provide it to P99. Sometimes when we visited P99, P99 would be in a state of undress. The males would be told to go outside whilst she was made presentable. I wondered what happened when there was no visitors. 10:39 10:40

I recall that the place smelt bad but at the time I assumed that must be normal. I can only compare the smell to that of a care home. Sometimes when we visited, we would be able to see P99's room. The room was basic and certainly was not the Ritz. I cannot remember too much about the staff during visits except that they did not seem to want us in P99's bedroom. There was never verbalised but the staff clearly directed us to the TV or sitting room where they would bring P99 to us. We would often be told to keep the visits short on the basis that P99 was tired. MAH reminded me of the film One Flew Over the Cuckoos Nest, like a prison without bars. There was not much freedom of movement, even the visitors were told to stay in the 10:40 10:40 10:40

TV and sitting room, which felt unnatural and restricted.

I found P99 very detached during visits and I attribute this to medication. It was my understanding that P99 was on antiepileptic medication. I am unsure what this medication was or if P99 was prescribed medication for anything else. I know that my family were never consulted about any aspect of P99's medication during her entire duration at MAH. I highly doubt that any change or variation was made to P99's medication during this time. 10:41 10:41

Over the time in MAH, P99's presentation declined. She would spend a lot of time pretty much slumped in a chair. Before visiting, we started to ring ahead and ask the staff if P99's medication could be reduced so that we could have a more meaningful visit. MAH staff would not give that assurance and would advise us that they could not determine when P99 would have a seizure, so the medication was essential. I am unsure how often P99 would have had seizures. 10:42 10:42

P99 did not seem happy when she was in MAH. She was happy when her family visited but she would say to her mother "Don't go, don't leave me". We were naive and thought this just meant that she missed her mother and her family. 10:42

During P99's time in MAH, she sustained numerous injuries. I have never been provided with a proper explanation. P99 broke her leg in and around 2012. The first we were aware of was when we went up for a visit and saw P99 with a cast on her leg. There was no credible explanation as to how P99 broke her leg. Instead, it was explained that P99 got frustrated and aggressive when she wanted to get out of bed and was unable to do so, and that this contributed to her falling. Essentially, it was self-inflicted. My family had never known or seen P99 to be aggressive so this did raise some uncertainty regarding the account provided. The nearest to aggression we had seen P99 display was her hitting her chest when saying love, to emphasise her feelings. 10:43 10:43 10:43

There would have been review meetings regarding P99 about twice a year. I remember at one of these meetings around 2014, 2015, we were told that P99 required a hip replacement. These meetings would have had a lot of people in attendance. They would have all introduced themselves and provided an update on P99. During these meetings we would raise concerns about P99's well-being and treatment whilst in MAH. The issues of concern were never acknowledged or discussed. In fact, the hip replacement never took place. MAH never proffered an explanation regarding this. 10:43 10:44

Over the period 2010 to 2017, P99 would have presented

with black eyes, a bruised face or other bruising. When my family asked about it, we would typically be told that P99 had fallen out of bed. P99's mother felt this was happening too often and I know she wanted to take it further. I feel very guilty about this because at the time, I talked her out of it. I could not believe that anything untoward was happening.

P99 was so vulnerable. I just did not believe that the people who had been caring for her for such a long time would have done anything to hurt or mistreat her in any way. I told my mother that they were medical staff and I queried why they would harm P99. I now believe that my mother might have had a point given the frequency of the bruising. 10:44 10:44 10:45

I'm not sure of the name of the ward that P99 was on initially but I do know that she was moved to Cranfield. I am unsure of the date of this move but I recall the marks on P99 became more regular at this time. Perhaps it was with my age and knowledge of my mother's concerns that I became more aware of the bruising and marks. 10:45

I remember P99 would seem to be hollow and distant and had what I can only describe to be like the 1000 yard stare. I believe that P99 had become institutionalised but I now think there may have been reasons other than the length of time that she had spent in MAH for her 10:45

demeanour.

P99's finances were managed by MAH. They deducted all her expenses and put the rest into a trust. My mother was told by MAH staff that if we kept receipts of whatever was brought in for P99, we could get the money back. My mother was P99's next of kin and would bring in clothes, bed linen and toiletries. She was told to bring receipts and MAH would reimburse her out of P99's money but she would never have done this as she would not take any of P99's money. 10:46 10:46

We never received a statement of accounts in relation to P99's finances during her entire time at MAH. In 2020", I believe it should read, "when P99 passed away, my mother was informed by BHSCT that P99 had a maximum of £22,000 in her account because this was the maximum that could be held. We were told that any money exceeding this amount was then claimed back by the government and they did not have a figure of the government recoupment." 10:46 10:46

CHAIRPERSON: Just pause for a second. The date in paragraph 21 should be, you say, 2020?

MS. TANG: 2020, yes, I believe so.

CHAIRPERSON: This is a signed statement. If we could just get a confirmation by email of that in due course. Thank you very much. Sorry to interrupt. 10:47

MS. TANG: "In and around 2016 or 2017, MAH contacted my mother via letter to advise that MAH had outlived

its purpose and that the patients were to be resettled in the community and MAH would be closed. Following the correspondence, I believe a call came from a lady named Heather who explained the decision to close MAH and move the patients into the community was not about funding and that the decision had been made and it was not up for debate. I remember feeling some sense of acceptance at this time as it was advised that they would be moving everyone out and it wasn't just P99. 10:47

None of my family were invited to contribute in relation to P99's resettlement plan of where she might live. This is something I would have been very keen to have been included in. I do not recall the name but a social worker from MAH advised that the care home selected for P99 was the best option and, in any event, there were no other options. It is so unsettling to think, as P99's family, we played no part in that decision. 10:48 10:48

I inquired whether the staff would be going with the patients as I thought given P99's difficulties this would make for a smoother transition. I was told they could not discuss it, and were not able to give me any information on staff deployment. I was informed that appropriate medical staff and OTs would be available to P99, and that she would receive the same standard of care as she had in MAH. 10:48

We were advised that Martin Residential Trust near Rathcoole was to be the community placement for P99. We had no option but to accept it. We were told that transport for P99 had been arranged and that her move to Martin Residential Trust would be arranged within days. P99 moved to Martin Residential in and around 2018, and my family were not told any specifics of her transfer. The transition must have been very difficult for P99 but, considering everything, I think she handled it really well. 10:49

P99 was happy in Martin Residential Trust and seemed to be well cared for. I wonder if P99 had been moved into the community earlier, she would have enjoyed a very much improved quality of life for several years. 10:49 Despite what P99's parents were told by the consultant, which opinion led him to agree to place her in MAH, P99 was capable of living past her early teenage years and, in fact, lived until she was 71 years old. She learned to say some words such as "mamma", and recognised her mother and family." 10:49

The witness then confirms that they do not wish to give oral evidence to the Inquiry, and provides a declaration of truth. They additionally provided a photograph of P99, which has been redacted. 10:50

CHAIRPERSON: Okay. Thank you. Do you feel strong enough to do one more or do you want a break?

MS. TANG: A short break would be very helpful, if you

don't mind Chair.

CHAIRPERSON: The next statement, is it P104?

MS. TANG: The next statement is P104 and then after that --

CHAIRPERSON: And then the Restriction Order? 10:50

MS. TANG: We have P105's mother and the final statement.

CHAIRPERSON: Would it be possible just to do this, because this is only three pages or four pages, isn't it? 10:50

MS. TANG: Yes, of course. The next statement is of P104, the internal page reference is STM-132-1. The statement is dated 10th day of August 2023.

"I, P104, make the following statement for the purpose 10:51
of the Muckamore Abbey MAH Inquiry. My connection with MAH is that I was a patient at MAH. The relevant time period I can speak about is between March 2013 and October 2014.

10:51

I was born on 17th September", the year is redacted. "I have one brother", whose name is redacted "and three sisters". Their names are redacted also. "I am the middle child of the family. My mother is called" name is redacted, "and my father", whose name is redacted 10:51
also. "My father has passed away.

Early childhood years were very difficult for me. I was the subject of Social Services intervention due to

concerns regarding paternal safeguarding issues. When I was around aged 15 or 16 years, I was placed for a period of time in the care of the Health and Social Care Trust. I am unsure what Trust I was placed with. I believe this was due to concerns surrounding domestic violence within the household. 10:52

I attended a primary school in Belfast", the name of which is redacted, "which is a mainstream primary school. I was badly bullied at that school and I would have absconded. I then attended a special school", whose name is redacted. "However, I am unsure what age I was when I attended there. I was quite young. I settled in really well to that facility, that school. I believe I was transferred to that school due to educational needs. 10:52 10:52

A turning point for me was when I was about 13 years old. I started getting into trouble at school. My father was in prison and I couldn't cope. I took it out on everyone else. I recall being frequently suspended and eventually I was expelled from school for fighting. Thereafter, I attended a secondary school", whose name is redacted, "which is a special needs school. I left school around 16 years old unable to properly read or write. 10:52 10:53

At age 16 years I was placed in a residential facility in Belfast", whose name is redacted. "This is a

resource centre for looked-after children. This was due to me being involved in criminality and taking drugs. I was running around with the wrong people. I was removed by the Trust as I was approaching 18 years. I accept this was due to my high levels of aggression and really being beyond any sort of parental control. Looking back at this period in my life, I feel I didn't really have a childhood. I grew up without my dad, who was an alcoholic and in prison for most of the time. My father was in prison for manslaughter and this really affected my mental well-being. 10:53 10:54

As a result of multiple childhood adverse experiences and several placement moves, my lifestyle pattern continued into adulthood. I have lead a very nomadic life with frequent periods of homelessness, and I became heavily involved with drugs and alcohol from the age of 13 for a period of time. 10:54

In 2013 I was convicted of serious assault. I was diagnosed with a learning disability. A Hospital Order was imposed at court and I was sent to MAH, whereby I was detained under the Mental Health Act. Initially I was admitted to Sixmile Ward, which is the regional low secure unit that provides care and treatment to male patients with a learning disability who have had mental health difficulties and have had contacted with forensic services. I had no prior knowledge of MAH and I had never heard of it before my conviction. I cannot 10:54 10:54

remember being told anything about what would happen when I got there except that I would be there for a good wee while.

I recall that when I was admitted to Sixmile Ward, there was only one other patient there and he had mental health issues. Generally there were two staff members on duty. I had my own room which had a bed, unit, toilet, shower, and a window. All the furniture was secured down and therefore could not be moved. Whilst in Sixmile Ward, I recall being out of my room during the day and I worked in the gardens, cutting grass and planting. I was always accompanied by a member of staff. Within Sixmile Ward there was a communal living room and dining room that was all in one large room. I was able to watch TV until about 11.00pm. I remember the food was always cold and repetitive. 10:55 10:55 10:55

I found the staff at MAH to be nasty. They were often cheeky and disrespected you. They acted as though they were above the law, and engaged in a lot of rough handling. I felt that I was bullied. 10:55

I remember that I was allowed to have visitors in a wee room. My solicitor visited me there, as did members of my family. My mum and my siblings would come to visit. Although MAH staff did not come into the room during a visit, there was a viewing panel in the door and people 10:56

passing outside could clearly be heard. I have no doubt that my conversations could be overheard. I always felt that I was watched during visits and that there was no privacy.

10:56

During my time at MAH, I recall an incident when another patient in MAH attacked me and a fight broke out. I was sitting on a chair when the other patient, who had mental health problems, unexpectedly hit me on the back of the head. I defended myself, which led to 10:56
a fight. A staff member named", the name is redacted, "H458, I do not remember his surname, intervened between the two of us and he pushed me with full force over a coffee table. I fell over the other side of the coffee table and smacked my head hard against the 10:57
ground. H458 tried to stop things and restrained me on the ground but the other patient was kicking me whilst I was on the ground. The other patient was put in his room. There was no examination from my medical expert to check if I had sustained an injury. I was not even 10:57
asked how I was. I was not aware if the incident was recorded by MAH.

I tried to complain to the boss. I do not remember their name. No matter what I said, I was not listened 10:57
to and I did not know how to take it further. They all supported each other. It was you against them and you could not cut through, so in the end there was no point.

When I was in MAH, I would have to be restrained a lot if I was involved in fights or arguments with other patients, for example. It's difficult for me to describe how I was restrained but it typically involved staff holding me, pinning me to the ground with my arms behind my back whilst their body weight was placed on top of me so that I was unable to move freely.

I was consistently pushed around in MAH by staff. I cannot recall their names. They abused me verbally almost daily and would also laugh at me. I recall being called things such as "an ugly fucker". It was not just one member of staff; most of those I dealt with verbally abused me. Most of the abuse, verbal and physical, took place in my room and I am unsure of the number of the room.

Staff would write down incidents in a wee yellow book. This was usually done by nurses before their hand over. However, the incident of the attack by the other patient was not recorded in this book.

I hated being in MAH. I would rather die than go back there. It was worse than my time in prison. They constantly made me feel like shit in MAH with how I was abused.

I absconded from MAH on two separate occasions. The first time I returned of my own accord and admitted

myself back in. The second time I was found by the police and brought back. When I was brought back on one of the occasions, I was strip searched. Initially two females staff members were going to carry out the strip search. However, I requested that it would two males instead and the women were replaced. The two male staff members then proceeded to strip search me and verbally abuse me, making derogatory remarks about the size of my penis. Given the choice of MAH and prison, I would pick prison. 10:59

In 2014 I had a Mental Health Review Tribunal. I cannot remember the exact date. No-one in my family was advised of the date of the MHRT, even though MAH had their contact details. I had tried to contact a member of my family so they could attend the MHRT. The result of the MHRT was that I was deemed fit for release. I was subsequently released from MAH in October 2014. There was no resettlement plan in place for my release or support. No-one in my family was informed of my date of release. I was simply released onto the street from MAH and there was no-one there. I had to telephone a member of my family to come and collect me. 11:00

Eventually, I got a two bedroom house with assistance of the Housing Executive. I did not have a learning disability social worker upon release from MAH, nor did I have any assistance whatsoever in resettlement. I

have asked my sister to assist in obtaining those supports for the future".

The witness concludes with a declaration of truth.

CHAIRPERSON: All right. 11:01

MS. TANG: There are no exhibits with that statement.

CHAIRPERSON: Do we move then in the next session to the Restriction Order?

MS. TANG: There is one final statement before that, which is slightly more lengthy. 11:01

CHAIRPERSON: All right. I won't ask you to press on with that, sorry. I'm just thinking, are we going to have to rise in order to deal with the Restriction Order? We can cut the feed to Room B pretty quickly, can't we? What we might do when we come back, we'll 11:01 read the next statement and go straight into the Restriction Order or does that cause you problems?

MS. TANG: I think a short break before the Restriction Order would be helpful.

CHAIRPERSON: A short break. Okay, no problem. We'll 11:01 take sort of 15 minutes now and then a much shorter break next. Thank you very much.

THE INQUIRY BRIEFLY ADJOURNED

11:02

THE HEARING RESUMED AS FOLLOWS:

CHAIRPERSON: Yes, Ms. Tang.

MS. TANG: Thank you. Good morning again, Chair and

Panel. I am going to read in the statement of P105's mother. The internal page reference for that is STM-137-1.

"I, P105's mother, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. My connection with MAH is that I am the mother of P105, who was a former patient of MAH. The relevant time period that I can speak about is 2017. 11:19

P105 is my only child. He is age 33 years old. I had no concerns about P105's development when he was young. My sister and my mother, who had their own children, did not indicate anything concerning about P105's development that would make them suspect that there was anything wrong with him. 11:20

When P105 was seven or eight years old, he was diagnosed with Attention Deficit Hyperactivity Disorder, or ADHD, without the hyperactivity, at the", restricted name facility, "which is now under the South Eastern Health and Social Care Trust. I was surprised at this diagnosis as I did not think he was hyperactive. Thereafter, P105 was placed under the care of Dr Gillian McPherson, who prescribed him with a drug called Ritalin. 11:20 11:20

P105 attended", the name of the facility is restricted, "which was a mainstream Irish school in", and again

restricted location.

"P105 did not play like the other children. He would get up and walk around, did not stand in a line, bumped into other children, and would not speak in Irish with the other children. The teacher suggested that he should be assessed by an educational psychologist. The educational psychologist assessed that P105 needed extra help at school, and he was placed in another primary school called", and the name is redacted. 11:21

"P105 would sit at the back of the classroom and was not learning anything. P105 had a third primary school move, to", another facility whose name is redacted, "where he stayed for a couple of years. Ultimately P105 attended a facility in", and address redacted, "which is a secondary school for pupils with additional educational needs, including moderate learning difficulties, autism spectrum disorders and dyslexia. 11:22

After leaving school P105 attended a facility" whose name is redacted "to undertake various courses for individuals with learning difficulties. In 2014 he started a computer class there. Education in general was positive for P105 and he is very intelligent. 11:22 P105 is temperamentally gentle and painfully aware of his social limitations. Growing up, P105 would have got picked on in the street because people saw him as different. P105 is currently 33 years old and is

diagnosed with a learning disorder, autism and, more recently, bipolar disorder. I am unsure of the exact dates of the various diagnosis.

In or about May 2017, I became increasingly concerned about a deterioration in P105's mental state. P105 had attended his annual review with Dr McPherson on 12th May 2017 and seemed reasonably well at that stage but from them his sleep became disrupted. He became increasingly restless and his conversation was bizarre. His community learning disability nurse, Laura Dixon, visited and was also concerned. 11:23 11:23

Dr McPherson was prepared to administer additional Olanzipine to P105 at her clinic but I was concerned that further delay might lead to a rapid decline in P105's mental state and I knew this when this would happen, he would get very bad. An ambulance was called so that he could be admitted to hospital. P105 was taken to MAH with myself, and my sister following. 11:23 11:23

P105 was admitted to Cranfield 1 on 18th May 2017 and I understand this was on voluntary basis. He was thought to be having a hypomanic episode, and it was agreed that he would be monitored and all aspects of his care reviewed. I believed that this would be a brief admission. 11:24

I have several issues arising out of P105's experience

in MAH in 2017, which primarily concerned neglect and staff attitude, use of seclusion and abuse. I also do not trust that P105's notes and records are always accurate in relation to what was told to me, especially when it relates to an issue of potential criticism. 11:24
In viewing the medical notes, I can see inaccuracies according to my recollection of events. I am really concerned as I believe this means things can be covered up and there is little that families can do to challenge this when provided with a so-called official 11:24
record.

I recall visiting P105 on 16th June 2017 after he had been in the seclusion room for nearly four hours. I noticed that P105 was not wearing his glasses and 11:25
subsequently became aware that he had not had his glasses on for five days. I was away on a short break to Donegal and unable to visit him during this time. P105 was knocking into things as, without his glasses, his eyesight was so poor that he is practically blind. 11:25
The medical notes indicated P105 was invading other people's space, and I do wonder how much of that may have been because he could not see and would have been so disorientated, given he did not have appropriate eye wear. P105's vision is so poor that this would have 11:25
been extremely debilitating for him. The thought of this incident causes me such distress. I attach a photograph of P105 wearing his glasses at exhibit 1". Exhibit 1 is redacted.

"There were many occasions when P105 would be inappropriately dressed. This included being overdressed for warm weather in warm fleecy clothes. He would be literally sweating. I feel that it is pivotal to note that P105 was dressed by the staff. If he was inappropriately dressed, then I assume it was because the staff were not paying attention or did not care. 11:26

I recall the temperature was generally very high on the ward. There were skylights and windows but there were no curtains or shutters so it would be very hot in there. I complained to the BHSCT about the temperature because I felt that there was a risk of heat stroke to some patients. After my complaint, I received a reply by letter and then a telephone call from a female manager. I recall the manager was upset with me for complaining and said I should have come to her first, and told me she would get fans into the ward. As far as I am aware, nothing was done about the temperature and I do not believe I would have received a letter, telephone call or any assurance if I had not gone to the manager first. 11:26 11:26

In my experience, MAH did not respond well to complaints. I also recall a previous incident involving a staff member called H71", name redacted, "who when I was raising concerns regarding P105's admission to MAH, he said "I wouldn't be making any 11:27

complaints. You're lucky we had a bed for him. We might not have a bed for him next time."

There was also a lack of proper attention to P105's feet and toenails, which got into a terrible state. At one stage P105's feet were covered in blisters and his heels were cracked. His toenails were frighteningly long, he had a fungal nail infection and at one point he lost a toenail. 11:27

I recall in and around May 2017, I had been out for a walk with P105 and he complained about his feet being sore. When we got back to MAH, I asked a nurse named H459 to look at P105's toes and feet. I phoned MAH that evening around 8:00 p.m. to find out the position but P105's feet had still not been looked at. P105 was unable to dress himself without help so I do not know how staff would not have seen the condition of P105's feet when they attended to his showering, personal hygiene and dressing. They must have known about it and decided not to deal with it. 11:28 11:28

I suggested that P105 wear sandals to let the air in to help with the fungal infection, but this was not done. I asked MAH to call the GP to look at P105's feet, which took a considerable time to organise. I was present when the GP, H314, attended P105. H314 told me that the toenails are just cosmetic, and I believed she was angry at being called for blisters and cracked 11:28

heels. As a result of my complaint, P105 was referred to a podiatrist but this referral should have been done long before they got so bad. I was told that staff could not cut P105's nails and podiatrist was off on annual leave. I think that there should have been some kind of procedure in place to ensure that P105's personal hygiene was looked after. If they had told me that his nails needed cut, I would have done this for him. 11:29

P105 lost four stone in MAH in a two-month period. At times this was very concerning, and I believe that it was due to the bad diet P105 had in MAH. P105 left MAH with vitamin and mineral deficiencies. P105 had low B 12, low vitamin D and low folic acid. I recall P105 being seen by a dietician following my concerns. She recommended rice pudding for him to put on weight rather than good food. I raised the issues around diet with the staff and they said they would not increase his food intake as the dietician was off on leave. I believe that if a dietician is off, the staff should have permission to increase or decrease food intake as needed. 11:29 11:30

There was no resident GP in MAH. Patients did not have proper access to a GP like everyone else. In my view, the patients only got to see the GP in an emergency which indicates that they were being treated as second-class citizens. 11:30

P105 was a vulnerable person who attended MAH when he was unwell and I trusted that staff would care for him and treat him with respect. I remember Nurse H459 shaving his face with a blunt razor, which caused his skin to bleed. I cannot understand why a nurse would do that. I felt that H459 was a bully. One time I told her I would be up to visit soon, and I remember her shouting at me saying "Do you know what we have had to deal with today", and put P105 on the phone. I found this very inappropriate and unfair on P105. 11:30 11:31

I was able to visit P105's bedroom on one occasion. It was just a bare room. P105's clothes had been removed, there were none of his cars on display nor any personal items there. I was told that P105's clothes had been removed because he tended to have a shower with his clothes on. P105 is very attached to me and was left without any personal items in his room in which he spent so much time. I found this to be so cruel and disturbing. 11:31 11:31

I felt completely disrespected by staff at MAH. There was no sense of etiquette given that I was P105's mother and sole carer. I am also aware of the fact that when I was not there, staff would laugh and make fun of me referring to me as "doctor", name is redacted, "apparently because of the interest I took in P105's treatment and wished to discuss his medications. If staff could show that level of disrespect to me, I 11:31

wonder what their treatment of patients was when their families were not there.

I feel that P105's behaviour was not appropriately managed and I understand that MAH resorted to putting him into the seclusion room. I understand this should only be used as a last resort. P105's notes and records show that he was put into the seclusion room on 8th June 2017 with the door being locked for less than an hour as P105 had tried to leave. Then on 14th June 2017, P105 was put into seclusion on three occasions for periods varying from just over half an hour to over two hours. Subsequently, on 16th June 2017 he was secluded for nearly four hours, from 1640 to 2100 hours. I recall when I visited P105 on 16th June 2017, he had just come out of the seclusion room. When P105 came out he was calm and lucid. I did not see there was any reason for him still to be in there, or if anyone had been monitoring to check if his behaviour had improved. I did not realise at the time that it was just a chair in the seclusion room. 11:32 11:32 11:33 11:33

Redacted name FLSW2 is given. "P105's social worker informed me that P105 was pushed and shoved around 30 times. I now wonder what was going on in MAH; if MAH staff had kept P105's glasses off on purpose. I am aware that when I was in Donegal on holiday on Tuesday the 13th, Wednesday 14th June, Thursday 15th and Friday 16th June 2017, P105 was left without glasses for the 11:33

entirety of this period. I noted these dates as when I called into see P105 on my way home, I arrived at around 9.00 p.m. as P105 was exiting the area which contains the seclusion room. I asked the male nurse where P105's glasses were. The male nurse said his glasses were broken, and he went off to fix them. There was a screw loose in his glasses and they were easily fixed. I complained about this to H460, the nurse in charge, and we had a meeting about the glasses. At the meeting the staff accepted that P105 had been left with no glasses. 11:34 11:34

I believe that P105 may have been secluded at other times when he was in MAH but I was not always told when he was in seclusion. I first found out about seclusion when I was told P105 needed new slippers because he had been in seclusion and used them to bang on the door. The slippers were destroyed. I am concerned about the effect of seclusion on P105. I raised my concerns with staff on several occasions as I considered it so unsatisfactory. No explanation was given about how it could have been allowed to continue for so long. I was simply told that I was to be informed if something like that happened again. 11:34 11:35 11:35

I found it concerning as to the level of discretion and control nurses had in relation to the seclusion decision. There is no record of P105 being given anything to drink, eat, or being taken to the toilet.

I did query whether P105 got water in seclusion as he needs to take a lot of water due to his Lithium medication, which is something that MAH should have been well aware of.

11:35

I understand that P105 was a voluntary patient when he was put in seclusion several times in June 2017. No-one explained to me the significance of P105's voluntary admission for the use of restraint or seclusion, or what I could do if MAH did want to detain P105. I query the legal of the seclusions whilst P105 was a voluntary patient. 11:35

Following some of those periods of seclusion, I also subsequently learned that P105 was detained under the Mental Health (NI) Order 1986, also known as the Mental Health Order, on or about 15th June 2017 for assessment. I received a telephone call whilst I was in Donegal on 15th June 2017 from the social worker H461 to say that staff wanted to lay hands on P105. I took this to mean restraint, and that I had to give permission. H461 told me if I did not agree, they just had to get another social worker and they could do it any way. I felt that I had no choice but to agree. Now having had sight of P105's note I cannot understand why MAH could not have called to tell me about concerns and that they were considering detaining P105. The notes show that the staff were considering detaining P105 from 9th June 2017, before I went on my short 11:36 11:36 11:36

break to Donegal. The notes also show that on the same day, I informed staff that I would be away in Donegal from Saturday 10th June 2017 to Friday 16th June 2017, and I provided them with two mobile contact numbers.

11:37

On the morning of Thursday 15th June 2017, a detention care plan was commenced. An email that day from H93 to Nurse H462 advised that social worker H461 will be up at 3:30 to read P105 notes before doing a joint ASW assessment. I was not told until this was effectively done and I was not provided with the detention care plan.

11:37

I was contacted by the police about an incident that was captured on CCTV involved P105. The PSNI told me that P105 had been kicked by a member of staff. P105 was on the ground and he was kicked. I attended a meeting with the PSNI and social worker present. I learned at that meeting that this had happened to other patients as well. That troubled me because it meant that it was not one person who had simply lost their temper under stress. It was difficult to think of P105 being hurt and not telling me, but not knowing whether he was hurt at other times before the CCTV was installed or that it had not been captured on CCTV is terrible.

11:38

11:38

I would often make suggestions as P105's mother which I thought to be constructive about P105's care. I would

hear nothing further about whether they would be taken up and, if not, why. In general communication with MAH was extremely poor.

In 2014 I learned that the Patient Client Council (PCC) were seeking feedback on why patients and their families did not complain more about their experiences in hospitals. I met with an interviewer and told her about my MAH staff experience and what H71 had said to me in January 2014 and how I interpreted it as a threat. I explained that for me there was a real fear it would affect the care that P105 would receive should he require it in future. I was not prepared to take the chance and insisted on absolute confidentiality and anonymity. I do not know what happened to the information I provided to the PCC. 11:38 11:39 11:39

P105's medication is well managed and he can safely stay at home with me. P105 has remained at home since his discharge in 2017. 11:39

I am very worried that if I complain about P105's treatment at MAH and he needs to go back there again, he could be targeted or poorly treated. I believe that it is a very important issue for families and something the Inquiry should consider. 11:39

I am concerned that when P105 was in MAH, his Lithium levels were not checked. The staff on one occasion

noticed P105's hands shaking and then they subsequently checked his Lithium levels, which were low. I believe that one of the reasons P105 was in MAH in the first place was because of low Lithium levels. Despite this, the staff in MAH were not checking his levels. 11:40

I am particularly concerned about the places in MAH that did not have CCTV such as bathrooms and bedrooms and, given the extent of abuse it has been acknowledged has occurred in MAH, P105 could have been abused in 11:40 those areas. I am aware that abuse continued to be caught on CCTV at MAH even though it was known that CCTV was operational. I think that staff should wear body cameras. I also think that something should apply to all facilities were people with serious mental 11:40 issues or severe learning disabilities are being cared for, given their vulnerability and the level of abuse that has been identified in such places in the past."

The witness goes on to provide her statement of truth. 11:41 Exhibit 1, as I have mentioned earlier, is a photograph of P105, which has been redacted. That is the end of the statement.

CHAIRPERSON: Okay. You want us to rise now and then we can come back in and deal with the application for 11:41 Restriction Order?

MS. TANG: Yes. Thank you, Chair.

CHAIRPERSON: In relation to the application itself, I will make an Restriction Order now so if the

Restriction Order is made, then it's not made relevant as it were. So I will make a Restriction Order in relation to the application. That means that when we come back in, the feed to Hearing Room B has to be cut and only those watching online who have signed confidentiality agreements may continue to watch.

I'll just take this opportunity now, only because I haven't mentioned it for sometime, the importance of keeping to any Restriction Order and the severe consequences if people are found to have breached them.

Okay. We will come back in five minutes.

MS. TANG: Five minutes. Thank you, Chair.

11:41

11:42

11:42

THE INQUIRY BRIEFLY ADJOURNED

THE INQUIRY RESUMED AT 2:00 P.M.

MS. BRIGGS: Good afternoon, Chair and members of the Panel. This afternoon the Inquiry will hear evidence from a witness who has been allocated cipher P102's brother. He has confirmed that he is content to be known by his first name, which is Harry. Harry is giving evidence to the Inquiry about his brother, P102, but I will also be using the patient's first name, which is Joe.

14:01

14:01

CHAIRPERSON: That is helpful. I understand the witness may have hearing difficulties so he needs us

all to speak up.
MS. BRIGGS: That's right. I understand that the microphone has been turned up as loud as it can go, but if needs be I will raise the volume as well. Thank you very much, Chair. 14:01

I should say there are three exhibits attached to the statement, and there are some photographs which will be shown on the screen in due course. We have also got Joe's discharge care plan and risk assessment when he left Muckamore, and his current care plan and risk assessment and current accommodation. 14:01

If there are no other issues at this stage, the witness can be called. 14:02
CHAIRPERSON: Yes. We will deal with it when he's here.

HARRY, P102'S BROTHER, HAVING BEEN SWORN, WAS EXAMINED BY MS. BRIGGS AS FOLLOWS: 14:02

CHAIRPERSON: Can I just welcome you to the Inquiry, and thank you very much for coming along to help us. You are in good hands with Ms. Briggs who is going to take you through your statement. All right. 14:03
MS. BRIGGS: Harry, we've met already. Hopefully you can hear me okay. My name is Sophie Briggs and I am one of the counsel team to the Inquiry. Can you hear me okay, Harry?

CHAIRPERSON: If you slow down, Ms. Briggs, I think it is going to help

MS. BRIGGS: I will slow down a bit.

Can you hear me okay, Harry? Are you struggling to hear me? 14:03

A. Yep. Yep, sorry.

1 Q. You can hear me okay?

A. Yep.

2 Q. Does that help, if I speak at this volume?

A. Can you turn it up a bit? 14:03

3 Q. Slow up a wee bit, okay? Turn it up a wee bit, did you say?

A. Yes.

4 Q. I will do my best to speak. Does it help if I stand away from the microphone. Is that okay? 14:04

A. That's okay.

5 Q. We'll do our best. If you can't hear me at any time or you are not sure what it is you are being asked about, just stop me and do let me know.

A. No problem. 14:04

6 Q. Okay. You're accompanied today by your granddaughter; is that right?

A. That's right.

7 Q. I have explained to you the process and how this is going to work. I am going to start by reading your 14:04 evidence, your witness statement into the record for the Inquiry, okay. You can sit back while that is being done, okay, Harry?

A. That's no problem.

8 Q. All right. You've got a copy of that statement in front of you there, Harry, yes?

A. Yes.

9 Q. Right. Okay. So the statement is dated 31st August 2023. It is reference STM-138-1. It reads as follows: 14:04

"My connection with MAH is that I am the brother of Joe, a former patient of MAH. I attach photographs of Joe at exhibit 1. The relevant time period that I can speak about is from 1964 to 2013. 14:05

My brother Joe was born in 1960 in the Mater Hospital, Belfast. There were six boys and five girls in our family. I am the eldest, being 17 years older than Joe, who was the second youngest. We all lived 14:05 together with our parents", and you say where that was in your statement.

"From an early age it was apparent that Joe had some difficulties. He did not speak when he would have been 14:05 expected to for his age, instead he would communicate through body language. For example, he would throw his head back, hitting it off the seat. My mother took him to the doctors who, in the language of that era, described Joe as being "deaf and dumb". Joe remains 14:06 non-verbal but would make noises or use his body to communicate. I was always able to understand him, as was the rest of my family.

Joe had behavioural issues in that sometimes he would purposely hit his head against the door and then laugh. He would also bang doors. He seemed to like the vibration or rhythm of it. Looking back at this behaviour, it now seems apparent that Joe was showing signs of autism but this was not a known diagnosis at the time. Joe has since been diagnosed as autistic and bipolar. 14:06

My parents arranged for Joe to go to a school for children with learning disabilities when he was three, nearly four years old. This was a residential school, and so Joe lived there. After a while, I went up to see him at the school with my parents. At this time I would have been around 20 or 21 years old. When we arrived, we were asked to wait and a woman came out to speak to us. She said that Joe had been moved to MAH around three weeks previous due to his behavioural issues. We were absolutely shocked that as a family we had not been informed of this. We immediately went to MAH to see Joe and, when we were there, we were told that they had assessed him and that they would be keeping him there at MAH. 14:06 14:07 14:07

Joe was three and a half years old when he was admitted to MAH. He was only ever a voluntary patient as far as I am aware. The first impression I had of MAH when we went to see Joe was that it was a nice place. I had no reason to believe otherwise. 14:07

My family and I visited Joe every week. We were able to take Joe out into Antrim Town for the day, mostly for the afternoon. Joe seemed content with that arrangement as a child. There was no sign of distress from Joe when visits would end, and he seemed happy on the children's ward.

At no time did anyone ever speak to us, however, about Joe in terms of treatment or updates on his care. At MAH for visits when you went in, Joe would just be brought down by a member of staff and then we would go off for the day. There was never any attempt to advise us about Joe's care in MAH, or whether any medical treatment was ongoing. I assume he had a social worker but we never knew who it was and we were never contacted by one. 14:08

I know Joe was on medication as a child, but I only know this as staff would have said that he had to be given medication to get him settled, but I am not aware of what exactly the medication was. 14:08

Joe seemed to settle in well to live at MAH as a child. There was a workshop for the older children, and sports activities. There were also Christmas parties and trips away. I cannot recall what year it was or what age Joe was, but I remember there was a trip to Kerry organised at one stage which he went on. 14:09

Joe was also allowed home on day trips with our family. Although he had permission to stay overnight with us, it was too unsettling for him, so he always returned to MAH.

As a family we always thought that Joe was in MAH to get treatment and be cured, after which time he would then come home. However, then on one occasion when Joe was a child of around 10 or 11 years old, the staff in MAH told us that Joe was settled in MAH and that this would be his home for life. This news was very upsetting, especially so for my mother. I cannot recall who told us this but it was stated as a fact, not part of any conversation with us as a family.

As Joe got older, he was treated by a psychiatrist in MAH and prescribed antidepressants. There was no consultation with us as his family about this, it was just done. In those days we did not ask questions, we trusted that the doctors knew what they were doing and were caring for Joe as he needed.

In 1972, when 12 years old, Joe was transferred to the Cushendun Ward in MAH. It was on this ward that his self-harming problems seemed to first occur. Previously there had been some record of aggression but it was in Cushendun when Joe was about 16 years old that he first inserted an object, a pass key, into his

rectum. At the time the family were not informed of this by MAH. It was only after the self-harm became more of an issue that we uncovered the full truth of what was occurring. Prior to this, we had believed Joe to be happy in MAH. 14:11

Joe was transferred to the adult part of MAH in or about his late teens. I remember thinking it did not seem suitable to have Joe on this ward. I believe that he was initially placed in Movilla Ward and 14:11 subsequently transferred to Moylena Ward.

Around this time our sister, who was the second eldest in the family, moved from the family home to Antrim so that she could be closer to Joe and visit him more 14:11 regularly. Even before my parents passed away, my sister took the most to do with Joe and his care in MAH. Letters would be sent to my sister in our home town and then to her in Antrim about any injuries Joe sustained because of self-harm. Unfortunately my 14:11 sister passed away in March 1996 and since then I have taken more to do with Joe.

During Joe's time on the adult ward more concerning behaviour and incidents unfolded. I recall on one 14:12 occasion being notified that there was an issue with Joe. I went up to MAH with a family member and, when we got there, a member of staff who had accompanied Joe to the hospital, I cannot recall who, told us that Joe

had put a key in his rectum. This staff member then asked if he could go for breakfast as he had been there all night, and he left. We waited to see the doctor and relayed what we had been told by the MAH staff member. The doctor arrived and asked if anyone had told us what happened to Joe and we repeated what we had been told about having a key in his rectum. The doctor was so furious we had been misinformed that he knocked over his chair as he got up and opened the door to speak to the hospital nurse, telling her that he wanted to speak to the MAH staff member. I told the doctor I was sick of this and that when you asked them anything, they don't give a straight answer. The doctor put an x-ray up on a screen and showed us where it could clearly be seen Joe had swallowed a key, proving we had been told a lie about Joe inserting it in his rectum. Joe was discharged back to MAH after surgery at Waveney Hospital, Ballymena, to remove the key. 14:12 14:13 14:13 14:13

The MAH staff member lied to us about what had happened, and this caused my family significant concern. There was no investigation or meeting held following this incident to avoid something like this happening again. 14:13

Usually when we visited Joe, we took him out to the cafe or away somewhere for a trip. There was no visiting room, for example, save for one occasion when

Joe was unwell, my family got to see Joe on the ward. When myself and my family went to visit him, Joe could not have got out of the ward fast enough but equally he did not seem to resist going back in after he had been taken out during a visit. Looking back now, I have no doubt there was fear in him. 14:14

My family always provided clothes for Joe and treats, especially sweets as Joe has always had a very sweet tooth. There were a couple of incidents that I found odd. On one occasion I had taken Joe up to get sweets in the shop canteen area, and Joe put them in his pocket. However, when we went back to the main area, Joe gave the sweets, brandy balls, to members of staff in the office. This was highly unusual because Joe absolutely loved sweets and would often take food or drink that was not his. This was not a natural thing for Joe. It seemed to me that Joe might have felt under some sort of pressure or might have been afraid. I never knew staff names as I had no interaction with them. As soon as you came for Joe or left him back, they turned the key and he was away. 14:14 14:15

On the other occasion when Joe was unwell and in bed, it was the only time that my family got in to see where Joe slept. There were four other beds in the room. We went to see him there and brought his usual parcel of treats. Joe did not open the parcel when I gave it to him, which was a first. Instead, Joe watched the 14:15

members of staff very carefully until we left the room. Joe appeared to be anxious. My brother-in-law also noticed this and commented to me at the time, "Did you see that", and I confirmed that I did.

14:15

I understand that incidents of self-harm, whether by inserting foreign objects or cutting himself, became very frequent and so serious that Joe could not be left with cutlery to eat a meal unsupervised as there was a real risk that he would swallow any spoons or use a knife to harm himself. Whatever the measures instituted by MAH, Joe was still able to frequently ingest spoons, keys and razor blades, as well as engage in frequent and serious self-harm that required treatment in hospital.

14:16

14:16

I was asking staff in MAH how it was happening he could swallow things, and they said we have a new system in place that when Joe is finished with anything, it was taken off him. Whilst it seems they did that, they forgot about other people at the table who had spoons, and Joe was lifting their spoons and doing the same again.

14:16

We didn't put in complaints as MAH staff would always pass it off as being Joe's fault. It was also different then, as Joe was still there and had to continue to live there so we were worried about any impact complaints would have on him.

14:16

Whilst MAH would have notified us when Joe seriously hurt himself, especially when he had to be taken to Waveney Hospital in Ballymena or Antrim Area Hospital, they did not provide any real explanation about why Joe did what he did or what MAH was doing about it. This would have been by way of a letter to our mother and father, and then when my sister moved to Antrim, to her. However, it is now clear from Joe's notes and records that we do not know about everything. 14:17

There were no safeguarding meetings or risk assessments following these incidents. If my family telephoned to speak to someone about Joe or some incident, they would not get clear answers. Staff would say they were not working at the time of whatever incident and did not know. They never got back to us with answers. 14:17
We did not always get called whenever Joe self-harmed by cutting himself and do not know what he would have cut himself with. Joe required frequent hospital treatment, including skin grafts, to treat wounds that he kept reopening. 14:17

Joe's notes record a real concern by medical professionals about the fragility of his scar tissue and the ability to properly deal with his wounds should Joe persist in reopening them or succeed in swallowing objects that required surgery to removed them. It then seemed that management were making an effort to move 14:18

patients out of MAH. When it was Joe's turn, we got word he would be moving out of MAH and asked to go to a meeting. A social worker, SW13, attended the meeting. She was a nice woman and very helpful to us. Anything we asked, she made inquiries and came back and told us the answer to our question. There was also a psychiatrist involved in the meeting, and my sister was there too. I am not sure but I think this meeting might have been held in MAH. 14:18

They wanted to send Joe to a couple of places in Antrim and outside Antrim, but we said no as we wanted Joe down to our home town, as that place is where the family now lived", and you have named that place. 14:18

"SW13 then connected us with Inspire Wellbeing. At one stage, however, there was an attempt to get my consent for Joe to transfer to the Southern Health and Social Care Trust. I came under pressure, I cannot recall from who specifically, to agree as it was claimed that the Southern Health and Social Care Trust would be able to handle things better, including all of Joe's finances. However, there was no explanation of how things would be better off for Joe. 14:19

Joe was eventually discharged in August 2013 to supported living accommodation through Inspire Wellbeing". You then go on to say where that was and what the name of that place is. 14:19

"Joe was about 53 years old and he had been in MAH for around 50 years. As Joe was not a detained patient in MAH, my family and I want to find out why it took so long to find Joe a suitable placement and for him to be moved out of MAH. We never asked before he was resettled as we never knew it was an option. I refer to documents relating to Joe's discharge from MAH and admission to his supported living accommodation, including the discharge care plan and risk assessment at exhibit 2." 14:20 14:20

Are you okay? Do you need a break or are you happy enough? Okay.

"Joe settled very well in the supported living accommodation and my family believes that Joe could have moved out of MAH much earlier if an appropriate placement had have been looked for or provided. In my view and from what my family was told, Joe's move from MAH only happened because a decision had been taken by those higher up to get all the patients who lived at MAH resettled in the community. 14:20

Joe is completely different in his new town. My family have been able to involve Joe much more in their lives since this move as he is closer to where we reside. There is no comparison whatsoever between Joe's life in MAH and his life now. My family are able to take him 14:21

to their own homes, to family celebrations such as weddings and parties. They also take him shopping and on day trips. I take Joe out three days a week, my sister takes him out one day a week, and my granddaughter takes him out every other week for the day. 14:21

We wanted any move for Joe to be a final move when it was confirmed he was relocating and the resettlement team agreed to that. I refer to Joe's current care plan, including risk assessment, at exhibit 3. 14:21

Joe is now in a house where he sits at a table with knives and forks without any issue or supervision of staff. The most amazing difference to me was one morning when I was in Joe's room and I saw Joe shaving himself with a proper open razor without any incident whatsoever. I got the impression that this was simply part of Joe's normal routine in his supported living accommodation. Such a thing would have been unheard of when Joe was at MAH. I cannot be sure of what was going on in MAH but I think Joe was self-harming or ingesting items as he wanted out of MAH. 14:21 14:22

At one point, the team leader in the supported living accommodation told me Joe was not washing his privates and that he was chasing carers out of the shower. I said I would go up early to see if I could help figure out what was going on, and I went into the shower and 14:22

indicated to him to wash himself and he did. When I checked, it turned out the water was cold and so Joe just wanted out of the shower as quickly as possible. The supported living staff got the shower fixed straightaway, but this shows there was an issue and not Joe acting out with the carers, for example. 14:22

On another occasion in 2020, Joe had some investigations due to there being blood in his urine. He was getting a wound on his groin dressed at the GP surgery when a nurse noticed something unusual and Joe was sent to Craigavon Hospital. Due to years of self-harming Joe's, skin around his crotch was like paper. It turned out there was a piece of pen inside the old wound. Joe used to hit his thigh and staff at the supported living accommodation did not know why. Joe was sent to another hospital where it was removed. The doctors thought it could have been inside Joe from as long ago as his time in MAH. I have no idea how it could have gone unnoticed but I believe that Joe had been scratching away at it to get it out. 14:23 14:23

Recently when I was with Joe, he reacted to a noise. Joe had never got his ears tested throughout his time at MAH. He was in there and that was that. They did not seem to bother with checking anything or treating him. Due to his reaction to the noise, I got a referral via the GP and Joe is now being tested so he can potentially get hearing aids to see if it will 14:23

assist him in hearing.

Joe's current medical conditions include renal failure and hypertension, which I have been told is related to Lithium medication that had been prescribed for many years to deal with a diagnosis by MAH of manic depressive illness. I want to understand how this level of medication was allowed to happen since Joe was under the complete of care of MAH from a young chilled of three and a half years old until he was around 50 years old. We were never told anything about his medication, we trusted MAH to look after him. 14:24 14:24

I requested Joe's medical notes and records to see what was reported during his time in MAH. The notes detail a long history of persistent self-harm, some leading to very serious injuries. The notes record instances when Joe might have done very serious injury to himself. These incidents were not always reported to my family. An entry from 4th November 1977, when Joe would have been around 17 years old, records that he was found at night in his bed breathless and cyanosed with a boot lace tied around his neck very tightly. There is then a record that Joe needed to be examined carefully at bedtime every night. Despite this, there is an entry from 5th January 1978 that Joe was found at night with the hem of his sheet torn off and wrapped tightly around his neck. These incidents were not reported to my family. 14:24 14:25 14:25

In 1982, there was a suggestion that Joe was harming so seriously because he liked the attention of the nurses and that an "admittedly unethical solution might be to provide Joe with the services of a sex worker as a means of teaching him not to engage in self-harm." So far as I was concerned, the main protection put in place for Joe was supervision that was supposed to be constant, a scrotal protective, always wearing boxes gloves unless he was eating and a blue all-in-one garment. I find these solutions extremely concerning. The only knowledge I have of efforts made by MAH was discovered through Joe's notes, which detail how incidents of Joe's self-harming were reported to the unit general manager and Mental Health Commission, and internal reports of a programme of developmentally socially stimulating activities, which were recognised as riskier but said not to have been successful. 14:26 14:26 14:26

The family has heard some very disturbing accounts about how patients were treated in MAH. There is footage taken by BBC Newsline which was shown on 16th March 2016 as part of a programme about MAH that shows Joe in MAH during the filming. My sister and I gave an interview for this programme. The manager of Inspire Wellbeing, I do not know his first name, spoke to me and said that MAH was horrendous and described it as being of the dark ages. 14:26 14:27

My family and I do not know exactly what Joe experienced in MAH. All we know is that Joe engaged in frequent self-harm, which has rarely occurred since history settlement in the community, and that his body bears the terrible scarce of that harm and the numerous surgeons required."

Joe, over the page then you say that the contents of that statement are true and correct to the best of your knowledge and belief, and you've signed that statement okay. First of all, I am going to ask you are you happy with the contents of that statement? 14:27

A. Yep.

10 Q. And you wish to adopt those as your evidence to the Inquiry this afternoon? 14:28

A. Yeah.

11 Q. Okay. I think we've got some photographs of Joe, and I think now might be a good time to put those up on the screen. We have an older photograph of Joe. Okay, well, this is a later photograph of Joe. We have got an earlier one at page 19, if we could show that as well. So, you're looking at Joe now, Harry, can you tell the Inquiry just a little bit about Joe; what he is like? 14:28

A. Well, at that time there, he was took everywhere and he seemed to settle down a bit. 14:29

12 Q. In this photo here?

A. That one, yep.

13 Q. I am going to ask you just to speak out for me, okay.

How old was Joe in that photograph?

A. Joe would have been 17, 18.

14 Q. And what about his personality; what would you say about his personality at that time?

A. Oh, it was great then. 14:29

15 Q. Yes, okay. What about that later photograph that we showed on the screen there, was that taken after he left Muckamore?

I can repeat that for you, Harry. I can repeat that 14:29 for you, okay. The later photograph which we are just going to get on the screen now, was that taken after Joe left Muckamore?

A. Yeah. That was in our house, wasn't it? That was in my home. 14:30

16 Q. That was in your home?

A. Yes.

17 Q. How many years ago do you think that would have been?

A. Joe is in Armagh now about 11 or 12 years. That would have been two or three years ago. 14:30

18 Q. Okay. What would you say about the personality? What would you tell the Panel about what he is like as a person?

A. He is all right.

19 Q. All right. You are a man of few words. You say in 14:30 your statement that he has been diagnosed now as autistic and bipolar. Can you remember when those diagnoses were made?

A. No. It would be long, would it?

20 Q. Harry, I am just going to say, if you can't remember, that's okay.
A. Yeah, I can't remember.
21 Q. You can't remember, okay. But it wasn't right back when he was in a young child, for example? It wasn't as far back ago as then, was it? You don't know? 14:31
A. No. Would it? I can't hear.
22 Q. You can't hear me. Do say to me if you can't hear what I am saying. Is this any better, and say no if it's not. Would it help if I was a bit slower? Can you hear me? 14:31
A. Yeah. Yeah.
23 Q. You can. Okay. I was asking you about his diagnosis of being bipolar and autistic because you mentioned that in your statement. Okay? 14:31
A. Yeah.
24 Q. Can you remember when he got those diagnoses?
A. I think we just got -- we knew before he left Muckamore Abbey.
25 Q. Before he left Muckamore, okay. And he was an adult then, I assume? 14:32
A. Yeah.
26 Q. Okay. All right. I want to ask you about how he communicates with everyone, okay, how he expresses himself. You've said in your statement that you and your family have always been able to understand him? 14:32
A. Yeah, yeah.
27 Q. How does he communicate with you?
A. Well, he would point to something. If he wanted go to

the toilet or anything, it was a tap, get up and go.

28 Q. Okay, so he would point at things. You say in your statement he would like sweet things, for example. How do you know with what he likes and what he doesn't like to do or to eat; how does he communicate that to you? 14:32

A. Joe, he was never very hard to work with. He soon let you know what he wants, you know, by making signs and pointing.

29 Q. And other people would be able to understand him okay?

A. Yeah, yeah. 14:33

30 Q. All right. I want to ask you about his hearing, okay. Was it always the belief until quite recently that he was deaf. Can you hear me okay?

A. No, I can't hear. I never heard you.

31 Q. Do say. See if you can't hear me, just say you can't hear me. 14:33

A. I can't hear you.

32 Q. Can you hear me now?

A. Yeah.

33 Q. Is that better? You've said in your statement about Joe's hearing; okay? 14:33

A. Yeah.

34 Q. You said that during his time in Muckamore that his hearing was never tested; okay?

A. Yeah. 14:34

35 Q. Was it always believed, did you as a family always believe, that he was deaf?

A. No. Because he banged doors, he laughed and heard them, you know.

36 Q. Okay. Would he have always reacted to doors banging?
A. Yeah. That was his problem, yeah.
37 Q. You've said in your statement that his hearing was never tested while he was at Muckamore; how do you know that? 14:34
A. He what in Muckamore? (Repeated by granddaughter). They didn't tell us, Muckamore.
38 Q. They never told you that they were testing his hearing?
A. They never told us a thing about Joe, no, about his hearing nor nothing. 14:34
39 Q. Okay. Given that he was reacting to doors closing, did you ever say or did the family ever say, well, we think he can hear?
A. We always reckoned he could hear a bit. I got a set of hearing aids, which I haven't got with me today, and I 14:35 put them on Joe --
40 Q. Did you?
A. -- and he started to try and talk to me.
41 Q. Okay. So they worked for him, did they?
A. Yes. I was talking to him and he kept as if he was 14:35 talking. So I have got a referral from a doctor to get his ears checked.
42 Q. And has he been to the doctor about that?
A. He has, yeah.
43 Q. He has; he has been to the doctor, okay. 14:35

I want to ask you about when he was a very young child. You said how you and your parents went up to his residential school --

A. Yep.

44 Q. -- when he was only three and a half, and he wasn't there and you were told that he had been transferred to Muckamore?

A. It was Jordanstown it was in. We asked for Joe. They brought us in to see another lady and she says, "Joe's not here, he is up in Muckamore Abbey." 14:35

45 Q. How did you and your parents react to that news?

A. We weren't informed of nothing. We just got in the motor and went up to see him. 14:36

46 Q. Was that shocking to hear?

A. They didn't tell us he was moved.

47 Q. Did they say why he was moved? I think you said in your statement they said it was because he had behavioural issues; is that right? 14:36

A. He might have been, all right, like.

48 Q. Did you ask why has he gone to Muckamore?

A. They said they couldn't keep him there because of the behaviour, you know. The type of the ones they had, the children, they were the same as him like, but Joe had the other problems, banging doors and, you know. It wasn't -- they just -- they said they couldn't keep him there because they couldn't control him. 14:36

49 Q. You've said that you and your parents went down to Muckamore then straightaway, I think; is that right? 14:37

A. Yeah.

50 Q. Did you speak to anybody from Muckamore at that time or did anybody from Muckamore speak to you to say he's here now and this is the treatment he is going to get?

A. That is what they told us when we went up, yeah.

51 Q. What did they tell you?

A. They said he was doing well, like. He was only a child.

52 Q. Did they tell you at that time we're going to treat him this way or we're going to give him this type of care or this is why he's here? Did they say anything about that? 14:37

A. No.

53 Q. I want to ask you about Joe's time on the children's ward; okay? 14:37

A. Yeah.

54 Q. You say in your statement that Joe seemed happy there?

A. Oh, he was, yeah.

55 Q. You said when you went down to see Muckamore, that it was a nice place? 14:37

A. Oh, it was, yeah.

56 Q. What made you say it was a nice place? Why did you think that?

A. Well, the surroundings were nice and the staff seemed nice. Like, all the staff weren't involved in anything. There were some good people in it. 14:38

57 Q. You go on in your statement to say that you received upsetting news when Joe was about 10 or 11, that Muckamore staff said to you that it was going to be said to the family that it is going to be his home for life. Do you remember that? 14:38

A. Yeah. That's right, yeah.

58 Q. What was your family's reaction to that news?

A. Well, we took things bad, very bad.

59 Q. At that stage did you think he was going to get out of Muckamore?

A. We thought he was coming home, yeah.

60 Q. Did the staff at Muckamore who gave you that news, did they provide any justification or reason for why Muckamore was now going to be his home for life? 14:38

A. Well, they said the problems that he had, no sense in sending him home because we could do nothing with him.

61 Q. And did you agree with that; did your parents agree with that? 14:39

A. Well, you had to. You had to take their word.

62 Q. You've told the Inquiry in your statement that Joe was transferred to the adult part of Muckamore?

A. Yeah. That's when all this, when all this ... 14:39

63 Q. When he was in his late teens. You've said in your statement that it didn't seem suitable for Joe. Why did you think it wasn't suitable for Joe?

A. Well, from he moved into one of the wards - I just forget which one - that's when everything, he started to do things. 14:39

64 Q. By do things, you mean self-harm?

A. Well, it says on the sheet, yeah.

65 Q. You've said in your evidence about how the children's ward was a nice place. How did the adult wards, how did they compare? 14:40

A. Well, you never even seen them. All you do is just go in the door and they went for Joe and brought him out to you. You didn't see anywhere of the circumstances

of where he lived, like.

66 Q. You do say, Harry, on one occasion you did get to see where he was sleeping, and that's because he was sick and he was in bed. Do you remember that? I'll repeat that for you. Harry. 14:40

A. Oh aye. Yeah, yeah.

67 Q. You have said in your statement that you remember going to his bedroom once when he was adult because he was sick in bed?

A. That's right, yeah. 14:40

68 Q. Can you remember, and tell the Panel, what the bedroom was like?

A. Well, there was four beds, I think. It was upstairs. The stairs were steep. Joe's bed - you could see he was coming up the stairs. We went up to see him and 14:41 the brother-in-law, we had the bag of his treats, if Joe sees the bag, it's the first things he wants. But he wouldn't take it, he kept looking at the guy going down the stairs. He waited til he closed the door before he took the bag. It was more or less was fear; 14:41 that is what we reckoned.

69 Q. You reckon it was unusual and he was afraid?

A. Yes, yes.

70 Q. What about the bedroom itself? You said there was four beds in the room. Was he sharing a room with other 14:41 people? Do you know that or are you not sure?

A. No. It was only an ordinary room and I think there was a toilet in it. Well, we never seen the whole lot of it, just a room with the beds.

71 Q. Okay. I want to ask you about Joe's self-harming because you've written about it in your statement, okay. You've said how that became a problem as Joe got older, he got through his teenage years and then he got into adulthood. At what age did you as a family realise that this was a big problem for him? 14:42

A. Oh, they did, yeah.

72 Q. What about the family, at what stage did you realise?

A. If you asked anything about him, you were just told he was on medication and that was it. They didn't explain nothing to you. 14:42

73 Q. What about his harming himself. At what point -- you've given evidence at the start they didn't tell you about one of the incidents?

A. I seen all the self-harming he done, supposed to he have done. Yet how could I explain, when we got him to Armagh he hasn't done a thing. 14:42

74 Q. Okay. If we move on then. I think we've got some photographs of his injuries?

A. Did indeed, yeah. 14:42

75 Q. Are you happy for those to be shown on the screen? I have asked you this before. Are you happy for those to be brought up at this stage?

A. Oh, aye. Oh, aye, yes.

76 Q. We have some photographs then. Okay. Can you see those photographs okay, Harry? Can you see those photographs okay? 14:42

A. Yeah, yeah.

77 Q. What is it we're looking at that there? Is that

something that he has done to himself?

A. Well, any self-harm he done, all you could see the wounds were deep, like. They weren't just cuts.

78 Q. Those ones we are looking at there, do you know whether he did that when he was in Muckamore? 14:43

A. He did, yeah. That's where he was, yeah.

79 Q. We've got a couple more photographs as well.

A. All the photos you are showing all happened in Muckamore Abbey.

80 Q. All of them happened in Muckamore? 14:43

A. Yes.

81 Q. Okay. How often when he was an adult were you hearing that he had done something to hurt himself?

A. To be honest, Joe had scars that we didn't even know he had. They didn't come and bring you in and tell you he 14:44 had done anything.

82 Q. Did they ring you sometimes or not at all?

A. No, they never said to any of the family that Joe, like, what he done or how he done it. Just you went for a visit, and that's -- you took him out and brought 14:44 him back. We didn't even know he had half of them.

83 Q. What about when you took him out. Did he ever try to do anything like this to himself when he was out with the family?

A. No, no. 14:44

84 Q. You've mentioned in your statement that Joe had treatment from a psychiatrist and he was prescribed antidepressants?

A. No, they never told us what medication Joe was ever on.

85 Q. Did you ever get speaking to that psychiatrist about his care?

A. What?

86 Q. So you've said in your statement that he was under the care of a psychiatrist? 14:45

A. Yes.

87 Q. I was asking you did the family ever get to speak to the psychiatrist about his care?

A. No. Never, never.

88 Q. You've said in your statement that you never knew any staff names because you had no interaction with the staff? 14:45

A. No, none.

89 Q. What about your parents or your siblings; did any of them? 14:45

A. They were the same. They just went for him, then took him out, handed and away on.

90 Q. When staff brought him down and you took him away, was it always different staff or were you seeing the same people? 14:45

A. It all depends who was on that day on the shift, you know.

91 Q. Was there ever staff members that were usually with him or was it different people?

A. Well, there was nobody with him. He was in a big room, in a lock-up, and they took him out for his visit. 14:45

92 Q. Okay. And he was there for 50 years; okay?

A. Yeah.

93 Q. At any time did you see any change in the staff, the

way that they introduced themselves to the family or made themselves known, or was it always like this?

A. No, no.

94 Q. It was always like this?

A. When you went there, the staff didn't speak to you. They just went and got Joe, handed Joe out and that was it. No update or anything. 14:46

95 Q. When you look at the 50 years that Joe was in Muckamore, did you see anything good happen to Joe in that time in terms of his happiness or his wellbeing or how he was behaving? Did you see any improvements in him? 14:46

A. Things changed over the years, from when he was smaller and taking him into the cafe. He was the same Joe, you didn't know any change in him. He could have been self-harming the night before but you couldn't tell with Joe. 14:47

96 Q. Did you see any improvements or lack of improvement in terms of how he communicated with people?

A. The only improvement you seen was when Joe got out of it. 14:47

97 Q. I want to ask you about Joe getting out of Muckamore, okay. He left Muckamore in 2013; is that right?

A. Yeah. He left in 2013, yeah.

98 Q. You've said in your statement about the process of getting him moved out of Muckamore. Can you recall how long that process took until he was moved in 2013? 14:47

A. Well, they keep telling us that they wanted to move him in Antrim, outside of Antrim. We wouldn't have it, we

wanted him in Armagh where the family was.

99 Q. Did that process take six months or a year or two years, or how long did it take?

A. There's something in my mind about 10 months.

100 Q. 10 months, okay? 14:48

A. Then they had meetings with all different psychiatrists.

101 Q. You've given evidence about a meeting that you had with a social worker - and we'll not name them, okay - a psychiatrist and your sister; you've said about that in 14:48 your statement?

A. Yeah.

102 Q. How did you feel that that meeting went? Did you think it went okay or it wasn't so good or it was good? What did you think of it? 14:48

A. What did she think of it?

103 Q. What did you think of that meeting that you went to? Were you happy with the way that meeting went whenever Joe was being moved out?

A. Oh, aye, yeah. 14:48

104 Q. You were happy with that?

A. Yeah.

105 Q. Were there other meetings? You have mentioned there when you were speaking that there were meetings. Did you go to any other meetings about moving him out of 14:48 Muckamore? Can you hear me okay, Harry?

A. Go ahead again, sorry.

106 Q. Did you attend just the one meeting about Joe being moved out or did you attend more than one?

A. Oh, there was -- it went on for a long time, the meetings, and we had attend them and stuff like that.

107 Q. Okay. You tell me if I'm wrong, okay. Would it be fair to say that resettling him was successful because he went to one place and he stayed there; is that fair enough? 14:49

A. Yeah, yeah.

108 Q. Would you say it was successful?

A. Of course, yes.

109 Q. Okay. I want to ask you about his life now, okay, now that he has moved and he is in his supported living, okay. How does his life compare now to when he was in Muckamore? 14:49

A. Like day and night.

110 Q. Why do you say that, Harry? 14:49

A. That's the only way I can put it.

111 Q. Why do you say that?

A. Joe at the minute he is happy. And he is intelligent, he's not ... He has no problems intelligence wise. If you set him anything, he'll do it. 14:49

112 Q. Before I hand over to the Panel who might have some questions for you, okay, I want to give you a chance to say to the Panel anything you want to say about Joe and his time at Muckamore. If there is anything you want to say. 14:50

A. Yeah. Well, Muckamore we were never informed about anything, his wellbeing. And any time you went up, most of the time you didn't even know that Joe self-harmed. It was only when we had the meetings to

get him to Armagh that all this came out for us.

113 Q. Okay. Thank you very much, Harry. I am going to hand you over to the Panel, okay.

THE WITNESS WAS ASKED QUESTIONS BY THE PANEL AS FOLLOWS: 14:50

CHAIRPERSON: Sorry. Could you look at paragraph 97 -- sorry, 47, of your statement. Could you just read that through again? It's about the two incidents when Joe was found in his room with things round his neck. 14:51

A. Yeah.

CHAIRPERSON: You told the Panel - well, you say in your statement - that these incidents weren't reported to my family. I just want to ask you this, by that stage you would have been about 34 years old, I think. 14:51

A. Yeah.

CHAIRPERSON: Were your parents still alive?

A. Yeah, yeah.

CHAIRPERSON: So is it possible the hospital told your parents? 14:52

A. No. No. No.

CHAIRPERSON: Because they would have told you?

A. There was no phones in them days really, and a letter would have come which... No. 14:52

CHAIRPERSON: And you're sure your parents would have told you about that?

A. Oh, aye. Yeah, yeah.

CHAIRPERSON: No, understood.

Harry, can I thank you very much for coming to assist the Inquiry and to tell us about Joe. We managed to struggle through.

A. As I say, Joe now at the minute, he is not the same Joe as you see in the photos. 14:52

CHAIRPERSON: Well, it is very nice to hear of the change.

A. Yeah. He has changed big time, yeah.

CHAIRPERSON: Brilliant. Thank you very much for coming to help us. If you would like to go with Jaclyn. 14:52

I am just going to ask the secretary to the Inquiry to come back in in a second to update me where we are for Wednesday. You may know, we're not sitting Monday, Tuesday, and then on Wednesday it looks, I think, as if we have only got one witness. Do we know if the witness -- you were originally going to schedule 9.30. 14:53

Ten o'clock, right. Ten o'clock next Wednesday, one witness. It will be a fairly short day. Thank you very much indeed.

THE HEARING ADJOURNED TO 10:00A.M. ON WEDNESDAY, 20TH SEPTEMBER 2023 14:54