MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY 21ST SEPTEMBER 2023 - DAY 59

59

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

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GWEN MALONE STENOGRAPHY SERVICES

APPEARANCES

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

INSTRUCTED BY:	MRS. SARA ERWIN MS. TUTU OGLE DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DWF LAW LLP
FOR PSNI:	MR. MARK ROBINSON KC MS. EILIS LUNNY BL
INSTRUCTED BY:	DCI JILL DUFFIE

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1 THE INQUIRY RESUMED AT 10:00 A.M. ON THURSDAY, 21ST
2 SEPTEMBER 2023 FOLLOWS:
3
4 CHAIRPERSON: Thank you very much. Sorry we're a
5 little bit late. I understand the witness needed to 10:07
6 settle herself and that's understandable. Okay, where
7 are we?
8
9 MS. KILEY: Just before the witness comes out, there is
10 a Restriction Order in respect of this morning's 10:07
11 evidence, so I propose to make that now and would ask
12 that the application itself be subject to restriction.
13 CHAIRPERSON: All right. We're getting used to doing
14 these. So, I will make a temporary Restriction Order
15 in relation to this application so that if the 10:08
16 application is granted, it is effective. I'll ask,
17 therefore, please, that the feed to Room B is cut. I
18 can take it there is no one in the room who is not a CP
19 or who has not signed a confidentiality agreement.
20
21 THE HEARING CONTINUED IN PRIVATE SESSION
22
23
24 AT 10:12 A.M. THE HEARING RESUMED IN PUBLIC SESSION
25
26 P109'S MOTHER, HAVING BEEN SWORN
27
28 CHAIRPERSON: Can I just welcome you again to the
29 Inquiry. We've met on a number of occasions previously

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1 and we have also just met outside. As I've said to
2 you, if at any stage you want to pause or stop, we'll
3 do so. Witnesses do sometimes get upset unexpectedly,
4 and that's perfectly understandable. If you feel you
5 can carry on after a short pause, that's great, but 10:12
6 don't force yourself, as it were. And you're sitting
7 with?
8 THE WITNESS: Stephanie, my advocate.
9 CHAIRPERSON: Thank you very much. Okay, Ms. Kiley.
10 1 Q. MS. KILEY: Good morning. We met just before you came 10:12
11 in. As you know I'm Denise Kiley, I am one of the
12 counsel to the Inquiry and I'm going to take you
13 through your evidence today.
14
15 When we met this morning, you let me know that you 10:12
16 would like to be known by your first name, which is
17 Catherine, isn't that right?
18 A. And you would also like your daughter to be known by
19 her first name, which is Alicia. That is how I will
20 refer you to both in your evidence today. You're here 10:13
21 to talk about Alicia's experiences at Muckamore Abbey
22 Hospital.
23
24 You have made a statement and I see you have a copy of
25 that in front of you. As you know, the first thing 10:13
26 that I have to do is to read parts of that statement
27 aloud for the record and then I will ask you some
28 questions. I explained to you just before you came in
29 that there was an application for a Restriction Order

1 in respect of some of the evidence, so there are parts
2 that we don't deal with in the first session, and then
3 we'll have a short break and deal with the remaining
4 parts of your evidence.
5 10:13
6 You will see, whenever I read out your statement in
7 front of you, a number of names of staff members have
8 been replaced with H ciphers. You have just at the top
9 of your table there a list, so you can follow along to
10 see who I'm referring to. When it comes to you giving 10:13
11 your evidence, if you want to say a name, can I ask you
12 just to pause and check the list and give me the H
13 number instead of their name. Okay?
14 A. I will do.
15 2 Q. If you're ready then, I'll start with the reading. Are 10:14
16 you ready, Catherine?
17 A. Yes.
18 3 Q. Okay. Your statement is dated 14th September 2023.
19 You say:
20 10:14
21 "I, Catherine, make the following statement for the
22 purpose of the Muckamore Abbey Hospital Inquiry."
23
24 At paragraph 1, you say:
25 10:14
26 "My connection with MAH is that I am a relative of a
27 patient who was at MAH. My daughter Alicia is a former
28 patient of MAH. I attach photographs of my daughter at
29 Exhibit 1."

1
2 We'll come to those at the end of your evidence.
3
4 You say:
5 10:14
6 "The relevant time period that I can speak about is
7 between November 2008 and July 2018.
8
9 Alicia was born in 1989 in the Royal Victoria Hospital,
10 Belfast, and is now 33 years old. She is one of five 10:14
11 children with older brothers, an older sister and a
12 younger sister. Alicia has complex medical conditions
13 which may be life-limiting, and a moderate intellectual
14 disability."
15 10:15
16 Then, Catherine, from paragraphs 5 to 8 you explain in
17 some detail the medical conditions that Alicia has. I
18 am not going to read all of those paragraphs aloud, but
19 in summary you explain that Alicia has epilepsy. She
20 also has tuberous sclerosis and, as a result of that, 10:15
21 she has a number of related conditions which she has
22 developed, and you explain that they include brain
23 tumour, renal tumour, facial angiofibroma, polycystic
24 kidney disease, chronic renal impairment, and low level
25 proteinuria. You then go on to say at the final 10:15
26 sentence of paragraph 8 that Alicia has had several
27 dangerous episodes requiring hospital admittance since
28 she was prescribed antipsychotic medications.
29

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1 Then from paragraphs 9 to 15, you explain a little bit
2 about Alicia's childhood and schooling. Again, I won't
3 read all of that but, in summary, Alicia went to a
4 special school, and then at age 17 you went on to
5 technical college where she learned social skills and 10:16
6 life skills. I'll pick up the reading at paragraph 15,
7 where you say:
8
9 "Alicia was doing well. She was able to go
10 independently to the shops and purchase items and she 10:16
11 could cook with support. She was functioning at a
12 relatively capable level and I thought Alicia would be
13 able to lead a fairly normal life, although she might
14 need support."
15 10:16
16 Then at paragraphs 16 to 23, you describe how your
17 daughter suffered a serious assault in or around
18 January 2008. Again, I won't read those out, the Panel
19 have all of those. In summary, you identify that as
20 being a time when Alicia's behaviour started to change. 10:17
21 You describe how she was not violent but was withdrawn,
22 and in February 2008 you say that your daughter was
23 prescribed Seroquel, which was an antipsychotic
24 medication. You describe how you were not told at the
25 time that that was an antipsychotic medication. You 10:17
26 say that you didn't feel that Seroquel helped Alicia.
27 At paragraph 23, you describe her as losing her
28 abilities and losing her personality at that time.
29

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1 I'll pick up reading then at paragraph 24. Following
2 on from that period, you say:
3
4 "I was finding it hard to manage Alicia. She was not
5 herself. She was not sleeping. She was talking to 10:17
6 herself and seemed to be what hallucinating. The
7 community nurse suggested that Alicia could be admitted
8 to MAH for respite and to see what could be done to
9 help her. I knew nothing in detail about MAH at that
10 stage. 10:18
11
12 On 6th November 2008, Alicia was admitted to MAH to the
13 Cranfield women's ward on a voluntary basis. The
14 Seroquel had not proved effective so she was admitted
15 for assessment and treatment. It seems that Alicia was 10:18
16 subsequently held on 20th November 2008 for treatment
17 under Article 12 of the Mental Health (NI) Order 1986.
18
19 When admission to MAH was first suggested, I thought it
20 would be a therapeutic place where Alicia would get 10:18
21 help from the PTSD from the assault that I believed to
22 be a significant factor. I believed that as it was a
23 hospital, they would help Alicia with the trauma she
24 had endured. I genuinely thought that I was doing the
25 right thing but I saw no sign of MAH trying to 10:18
26 understand what had caused Alicia's mental
27 deterioration by exploring the effects of the assault.
28 Little seemed to be done for Alicia apart from
29 increasing the medication.

1
2 Despite Seroquel not having shown to be effective, her
3 dosage was increased. During Alicia's first placement
4 at MAH, I remember that I was advised not to visit
5 Alicia to give her a settling-in period. I did visit 10:19
6 Alicia but not as often as I would have liked because
7 they advised me she needed to settle in. I wasn't as
8 aware of the circumstances in MAH at this time as it
9 was the first initial period.
10 10:19
11 Between Alicia's discharge from MAH in December 2008
12 and August 2014, her behaviour was challenging. She
13 experienced seizures in a way she had not previously;
14 she was aggressive, and flare-ups in her angiofibroma."
15 10:19
16 Then from paragraphs 29 to 32, Catherine, you refer to
17 a number of clinical investigations that Alicia
18 underwent outside MAH during that time period, and you
19 explain how you had continued issues with her
20 medications at that time. 10:20
21
22 I'm going to pick up the reading at paragraph 33, where
23 you say:
24
25 "The management of Alicia's epilepsy and behaviour with 10:20
26 medication continued to be challenging. I was keen to
27 have Alicia's medication changed but I was told that
28 Alicia would need an admission to achieve that. At one
29 point later, I think 2017, Alicia, while a patient in

1 MAH, was attending an annual MRI appointment in the
2 Royal Victoria Hospital, Belfast. She was transported
3 by MAH staff and I was meeting her there. By the time
4 I arrived, Alicia had already undergone the MRI. I had
5 always been adamant during other similar MRIs that 10:20
6 Alicia should not receive the intravenous dye as it had
7 a small risk due to her epilepsy, but on this occasion
8 I believe she did receive the dye, and I would like to
9 know who gave hospital staff permission to do this as
10 Alicia would not have been able to consent to this. 10:21
11
12 On 13th August 2014, Alicia was admitted to MAH on to
13 Cranfield women's ward on a planned basis as a
14 voluntary patient due to a deterioration in her
15 behaviour at home and to have her medication adjusted. 10:21
16
17 During her admission, Alicia accused staff of being
18 rude to her. Her PARIS notes from 13th August 2014
19 record that MAH staff stated this was untrue. This is
20 included as parts of the extracts of her PARIS notes 10:21
21 that I have included at Exhibit 2. She also said that
22 two bruises on her arm was because someone had nipped
23 her. Again, the notes record that Alicia subsequently
24 retracted that. Given Alicia had made these
25 allegations, I want to know why procedures around this 10:21
26 incident were not then followed about her complaints.
27
28 Alicia is also recorded behaving bizarrely and
29 inappropriately at times, being aggressive towards the

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1 nurses, and requiring PRN medication. I do not think
2 this is necessarily being accurate as there is no
3 context provided. I am aware of Alicia making
4 allegations against staff and I am aware that Alicia
5 had bruising on her arm. No proper processes were ever 10:22
6 followed by MAH and no one spoke to me about these
7 incidents after they occurred.
8
9 I did not consider Alicia's behavioural issues had been
10 addressed or that she had been very much helped by the 10:22
11 time she was discharged from on 3rd November 2014. As
12 far as I could see, all that happened was that her
13 antipsychotic medication, Amisulpride and Epilim, was
14 changed, but no behaviour therapy was provided and
15 there was no change to the basic approach. I was 10:22
16 concerned about the apparent failure to consider the
17 impact of Alicia's medication on her complex
18 conditions, including her epilepsy. I raised my
19 concerns but at this stage I was not aware of the
20 complaint process. 10:23
21
22 Alicia told me that she had been physically abused in
23 MAH. I raised with the head nurse that there was a
24 bruise on the back of Alicia 's hand, but at the time I
25 was not fully aware of the complaints procedure at the 10:23
26 time. I cannot recall the name of the head nurse.
27 There was no follow-up after I raised it with the head
28 nurse. A patient also nipped Alicia's arm and Alicia
29 threw a cup in retaliation. This behaviour continued

1 throughout Alicia's time in MAH, and I believe that it
2 was a learned behaviour from being in an inappropriate
3 environment. This behaviour continues occasionally
4 today.
5 10:23
6 My mother, Alicia's grandmother, died on Friday, 30th
7 January 2015, and Alicia responded very badly to that
8 loss. In response, Alicia's social worker, H554,
9 contacted the consultant psychiatrist in Intellectual
10 Disabilities in the Belfast Trust on 2nd February 2015 10:24
11 expressing the deterioration in Alicia's mental state.
12 The outcome was that emergency respite would be sought
13 for Alicia at Trench Park Respite and Supported Living
14 Service, her Amisulpride to be increased mand I was to
15 be continue to administer Diazepam. 10:24
16
17 Alicia was admitted to Trench Park that week for one
18 overnight. They could not offer further assistance due
19 to a strain on services. Respite within the community
20 was very limited. 10:24
21
22 I contacted the GP on 7th February 2015 seeking an
23 emergency readmission to Trench Park for respite due to
24 P109's behaviour that was very challenging. She was
25 not sleeping, up all hours, and in and out of the 10:24
26 house. It was explained that an assessment that
27 evening for Trench Park would be difficult, and I said
28 I would keep Alicia safe overnight. There was no place
29 available at Trench Park the following day, and MAH

1 advised that they could admit Alicia if her behaviour
2 was very challenging, and it was on a voluntary basis.
3
4 Alicia declined to go to MAH and arrangements were made
5 to detain her. Alicia was taken to her GP, where there 10:25
6 was a social worker, and papers were completed which
7 Alicia tore up and said 'You can't do this to me, I
8 have my human rights.' She was then taken by ambulance
9 to MAH. It was a very traumatic experience for myself
10 and Alicia. I did not want her to go, and I wish there 10:25
11 had have been more community support to avoid this
12 admission.
13
14 On 8th February 2015, Alicia was admitted to MAH, on to
15 the Cranfield women's ward as a detained patient under 10:25
16 Article 4 of the Mental Health Order for assessment.
17 It was the first time Alicia had been detained and I
18 had no idea what to expect. I was not given any
19 pamphlets about MAH or information about detention.
20 Alicia was discharged from MAH in March 2015. Alicia 10:26
21 would have had bruising throughout this period. When I
22 asked about the bruises, the staff would have blamed
23 other patients for causing the bruising.
24
25 Whilst MAH was aware of the stressors in Alicia's life 10:26
26 to include the death of her grandmother, I saw no
27 evidence of any empathy being shown to her. I
28 initially believed that Alicia was going to MAH to get
29 help but she was never offered any psychology input or

1 talking therapy, which she really needed after the
2 death of her grandmother.
3
4 She also had seizures and lost power in her legs,
5 resulting in her falling, although remaining conscious. 10:26
6 I recall this incident and Alicia was in Antrim Area
7 Hospital at this time. I told the hospital that I
8 believed this incident was due to her medication. I
9 spoke to the neurologist at Antrim Area Hospital. I
10 said that every antipsychotic that was prescribed 10:27
11 Alicia resulted in her having grand mal seizures, which
12 were life-threatening to her. Alicia was discharged on
13 3rd March 2015, with her Amisulpride having been
14 reduced and a plan for her to resume day care the
15 following week. 10:27
16
17 Whilst Alicia's behaviour had initially improved since
18 her discharge from MAH, by in or around May 2015 I felt
19 Alicia's mental statement was slipping and she was
20 becoming more aggressive. I continued to be concerned 10:27
21 about the impact of Alicia's medication, e.g. increases
22 in Amisulpride in MAH had led to an increase in seizure
23 activity. Additionally, I thought Amisulpride might be
24 associated with Alicia's weight gain and obesity as
25 well as her lack of periods. I believe these concerns 10:27
26 at Alicia's review on 8th June 2015 in Beech Hall. I
27 believed that Alicia needed community support and
28 psychology input. A discharge letter from 17th August
29 2008 from H223 following her admission to MAH on 7th

1 November 2015 recognises the difficulties with Alicia's
2 medication.
3
4 On 17th August 2015, Alicia was readmitted to MAH on
5 Cranfield women's ward as a planned admission for 10:28
6 review of her medication due to reported side-effects
7 and significant hyperprolactinaemia, as well as the
8 link with Alicia's suspected diagnosis of Polycystic
9 Ovarian Syndrome.
10 10:28
11 I think numerous changes in Alicia's medication a
12 significant impact on her and her behaviour, and I
13 believe that Alicia's behaviour was a combination of
14 effects to her medication and learned behaviour, and do
15 not believe that her medical records accurately reflect 10:28
16 this. I would say it was a prison element - go in a
17 petty criminal and come out a hardened one - and Alicia
18 ended up institutionalised.
19
20 Alicia was discharged on 3rd November 2015 with a 10:29
21 referral to psychology services to address the trauma
22 and follow-up prescription to deal with an interdigital
23 rash she had developed, which MAH considered was in
24 keeping with scabies. The prescription of Lamotrigine
25 and the development of a rash is the subject of a 10:29
26 complaint I made during Alicia's subsequent admission.
27 This is referred to in a letter from Belfast Trust
28 dated 3rd June 2016. I have included this
29 correspondence at Exhibit 3.

1
2 Alicia's mental health deteriorated and there was a
3 violent outburst, for example smashing cups on the
4 ground, verbal abuse of myself. As a result, Alicia
5 was readmitted to MAH onto Cranfield women's ward on 10:29
6 7th November 2015 on an emergency basis.
7
8 Although it was acknowledged that Alicia had suffered
9 trauma, no focused trauma work was undertaken with her.
10 H40 agreed at an MDTM that Alicia would benefit from 10:30
11 exploring a behavioural route to treatment as opposed
12 to medication.
13
14 I wanted an independent second opinion with regards to
15 Alicia's medication, and so H553 saw Alicia on 11th May 10:30
16 2017 and advised neuroimaging to monitor any change in
17 her brain tumour, and careful titration of her
18 medication to address her behavioural issues. This was
19 Alicia's longest admission, lasting nearly three years,
20 until her eventual discharge on 13th August 2018. 10:30
21 Alicia became a delayed discharge patient but due to
22 the lack of community facilities, she remained in MAH.
23 I also had requested Alicia return home with a bespoke
24 care package. Alicia has returned home to me
25 throughout her admissions on a regular basis. Several 10:30
26 serious issues arose concerning errors with Alicia's
27 medication that led to a serious adverse reaction,
28 mismanagement of a transfer to other wards, and the
29 handling of complaints.

The issue over Alicia's Lamotrigine prescription started during her last admission to MAH from August to November 2015, when H40 prescribed it as an alternative to Epilim and gradually increased as Epilim was reduced. H40 was Alicia's consultant psychiatrist. It was explained to me that some patients can have a severe allergic reaction to Lamotrigine which manifests as a rash, and should that happen to Alicia, she would be taken to Antrim Area Hospital immediately. I was given no paperwork about adverse reactions and, shortly afterwards, H40 went on holiday and left H338 in charge. He was a junior psychiatrist, a core trainee 2, CT2.

Alicia developed a rash on her hands and on her arms on 1st November 2015 just before she was discharged on 3rd November. I asked the ward staff about it, and they said it was thought to be scabies and they had applied Permethrin ointment. I was given the ointment and told to apply it twice a day. I was not given any other information about scabies or how to manage the risk of transmission, even though it was known there were others living with her; nor was it explained how the scabies diagnosis had been reached. I was doubtful about the diagnosis as I had seen scabies before. I specifically asked whether there were any other cases on the ward given Alicia had been in MAH for the last two and a half months, and was told there were no other

1 cases.
2
3 After Alicia was discharged, the rash spread across her
4 body. Alicia's social worker, H554, saw the rash when
5 she was assisting her the following morning at the day 10:33
6 centre. However, H554 was advised that Alicia could
7 not attend day centre due to the diagnosis of scabies
8 and its contagious nature. I knew that there was
9 something wrong as Alicia was restless and agitated. I
10 called Alicia's GP who prescribed an antihistamine, 10:33
11 Piriton. Within half an hour of getting the
12 antihistamine, Alicia was behaving very strangely and
13 hallucinating.
14
15 On 7th November 2015 I took her to the A&E in the Royal 10:33
16 where I told the staff that Alicia had been prescribed
17 Lamotrigine, she had developed a rash and was
18 presenting very strangely, she was hallucinating,
19 paranoid and hyper. I told them that I had brought
20 Alicia because of the deterioration in her mental 10:33
21 health. By this time the rash had spread all over
22 Alicia's body.
23
24 The Royal transferred Alicia to MAH by ambulance where
25 she was readmitted to Cranfield 1 women's ward. I 10:33
26 believe that due to the fact that Alicia had just been
27 discharged, the Royal thought that it was her mental
28 health and she was not assessed medically. My son went
29 with Alicia and I followed with my daughter-in-law in a

1 car. H40 was still on leave. Alicia was admitted that
2 night and I was telephoning the wards throughout the
3 next morning and afternoon. I spoke to a nurse, who
4 said that Alicia had not eaten or drank in 24 hours and
5 explained that I was concerned that Alicia did not have 10:34
6 scabies. The out-of-hours rota GP came in and checked
7 Alicia and agreed that it was scabies. I insisted that
8 a dermatologist should see Alicia. I went to MAH to
9 seek to H338 because I was so concerned about the rash.
10 When I spoke to H338, I made it clear that H40 had said 10:34
11 there was a risk of an adverse reaction from
12 Lamotrigine and that any rash needed to be monitored.
13
14 When I saw Alicia, the whites of her eyes were yellow,
15 the rash was very visible, her lips were peeling and 10:35
16 her fingertips were blue. She looked very sick. I was
17 very worried that Alicia was dehydrated because she had
18 not drunk anything for 24 hours. I took her to the
19 Cosy Corner to get her some Coca-Cola. She was very
20 weak. On return from the Cosy Corner, I met H77 and 10:35
21 requested a private conversation with myself and
22 Alicia. I raised my concerns over the scabies
23 diagnosis, reiterated H40's advice, and H77 said he
24 would speak to H338.
25 10:35
26 I went to see H338 with my son-in-law. I spoke to H338
27 and said I was very concerned that this was not
28 scabies. H338 said that a GP had examined her. I felt
29 that my gut instinct was saying that there was

1 something seriously wrong. I felt that I was shut down
2 by H338. I said that I would make a complaint because
3 I was not being taken seriously. He said that it was a
4 case of scabies that had become infected. I again
5 requested that Alicia was seen by a dermatologist and 10:36
6 reiterated H40's advice again. Instead, he just ended
7 the meeting.
8
9 I made several complaints that I was not being taken
10 seriously. I made a complaint to H40 and to H50. I 10:36
11 made a complaint to Musgrave. I also met with someone
12 from the Complaints Department in MAH. I think I maybe
13 complained 10 or 12 times. I have including
14 correspondence with Belfast Trust in relation to these
15 complaints in Exhibit 4. I went to see a solicitor but 10:36
16 did not pursue this. I knew at this stage that MAH was
17 not the place I thought it was.
18
19 I went home and started looking up things on Google. I
20 realised there was a risk of a very serious adverse 10:36
21 reaction to Lamotrigine, especially where sodium
22 valproate, e.g. Epilim, was also being taken. I noted
23 that Stephens Johnson Syndrome was a rare but
24 potentially fatal reaction. I was very afraid that
25 overnight Alicia might die due to this reaction. I got 10:37
26 in touch with Alicia's social worker, H554, the next
27 day and begged her to intervene to check that Alicia
28 did not have itself Stephens Johnson Syndrome. The
29 social worker telephoned the ward and by the afternoon,

1 I received a call from the female consultant who said
2 that they would stop the Lamotrigine because Alicia was
3 having a reaction. The female consultant had spoken to
4 a dermatologist by phone. I was frustrated that this
5 had not been done sooner as Alicia had been taking 10:37
6 Lamotrigine for about two weeks until it was stopped on
7 13th November 2015. I was also concerned that there
8 appeared to be no follow-up with the specialist, or
9 investigation as to the possible impact on Alicia's
10 kidneys as she already had compromised kidneys, nor did 10:38
11 it seem that any creams were prescribed for her skin.
12
13 I then went to visit Alicia and saw H77 at Cranfield.
14 Again I asked for Alicia to be seen by a dermatologist
15 immediately, but Alicia was not taken to Antrim Area 10:38
16 Hospital to be checked. Her bloods were checked and I
17 remember that there was a result from her blood tests
18 that showed on autoimmune reaction. I believe there
19 was a high liver reading. This was never explained to
20 me. 10:38
21
22 I was so concerned that on 24th November 2015, I took
23 Alicia from MAH to see a consultant dermatologist at
24 the Ulster Hospital Dundonald privately. She examined
25 Alicia and said that she had been a very, very sick 10:38
26 woman, and she said thankfully I was wise to beg for
27 the Lamotrigine to be stopped. The consultant
28 dermatologist provided a report to H40, dated 24th
29 November 2015 when the rash was still all over Alicia's

1 body, and concluded that the appearances are consistent
2 with a resolving drug reaction, and she recommended
3 that Lamotrigine is avoided in the future. The
4 consultant dermatologist prescribed special washes,
5 moisturiser and ointment. Given the seriousness of the 10:39
6 reaction and ill-health Alicia suffered result of this
7 incident, I would ask the Inquiry look into the
8 medication and treatment Alicia received around this
9 time.
10 10:39
11 I was very concerned that MAH did not consider that
12 Alicia might have had a serious reaction to the
13 Lamotrigine. They refused to listen to me and
14 persisted with an improbable diagnosis of scabies. I
15 would like the Inquiry to investigate how this whole 10:39
16 episode is recorded in Alicia's medical notes and
17 records, and whether there was any consideration given
18 by MAH to a link between Alicia's adverse reaction to
19 Lamotrigine and her chronic kidney failure described by
20 H223 in his discharge letter of 17th August 2018. 10:40
21
22 From notes I have seen that covers the period, I can
23 see no reference to the Lamotrigine incident, although
24 I have seen a discharge letter from H338 dated
25 9th November 2015 that states Alicia had tolerated the 10:40
26 introduction of Lamotrigine well and it was gradually
27 increased. He also said that her reason was in keeping
28 with scabies - which was obviously proven not to be
29 correct. However, in an email dated 20th October 2016

1 sent to my MP, Paul Maskey, H555, Public Liaison
2 Officer in Belfast Trust, confirmed that during
3 Alicia's admission she appeared to have a reaction to a
4 number of antipsychotic medications which remained
5 under review by her clinical team and consultant 10:41
6 psychiatrist. I have included this in correspondence
7 at Exhibit 5.
8
9 I continually tried to explain to MAH that the
10 prescribing antipsychotic medication to deal with 10:41
11 Alicia's behaviours led to increased seizures, and I
12 was concerned about the impact of this on Alicia given
13 her tubular sclerosis and associated brain tumours, and
14 Alicia's kidney disease. I was not taken seriously.
15 10:41
16 I had educated myself and knew that what I was stating
17 was factual in relation to Alicia's medication being
18 the problem and causing her to be ill, but I presumed
19 by this stage that no one would listen to me as they
20 never did. I was not being listened to which resulted 10:41
21 in me feeling concerned, worried, and petrified. I
22 questioned myself over and over what the end result
23 would be - would Alicia die or would she end up in
24 hospital long-term? I was watching Alicia having
25 seizures and worried what long-term impact they would 10:42
26 have on her. I felt that if the medical professionals
27 had only listened to me, all of this could have been
28 avoided. I felt that the doctors made me feel
29 belittled, and that they had the power over my

1 daughter.
2
3 Despite suspecting there was medical negligence, I was
4 afraid as I was fully aware that Alicia was still in
5 MAH's care. Continuously I felt as a mother, I could 10:42
6 not protect my daughter as I was not taken seriously,
7 and my rights were diminished. I felt that what I was
8 saying was not important. No one knows their daughter
9 like a mother, and still the professional medics did
10 not listen to me. 10:42
11
12 A discharge letter dated 5th May 2016 from a consultant
13 neurologist in the Antrim Area Hospital explained that
14 Alicia was admitted to the hospital from MAH after she
15 had a cluster of seizures. It refers to her having 10:42
16 been intolerant of Lamotrigine and Tegretol, and that
17 MAH had introduced Chlorpromazine, which had been
18 gradually increased resulting in a cluster of major
19 seizures which then required admission. The doctor
20 noted Alicia's previous brain imaging showed evidence 10:43
21 of multiple brain tumours and a giant cell astrocytoma.
22 He noted the relationship between an antipsychotic
23 being introduced and Alicia having a cluster of
24 seizures, and concluded with suggesting that
25 Chlorpromazine be withdrawn completely. 10:43
26
27 Alicia was subsequently placed on Haloperidol as an
28 alternative. My desire for Alicia to be taken off
29 antipsychotics, which I believe means that she needs to

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1 still on the Epilim for seizure control, is recorded in
2 H223's MAH discharge letter of 17th August 2018.
3
4 On 4th July 2016, the patients from Cranfield women's
5 ward, including Alicia, were moved to Killead Ward. I 10:44
6 understand that H40 was on leave when the decision for
7 the transfer was taken. I asked the staff on the ward
8 whether it was a planned move and was told that they
9 had been given two days' notice. I understand that it
10 was decided by H507, who was the senior manager. It 10:44
11 seemed there was no protocol about consulting the
12 patients or families about this, it was just decided.
13 H555 in Belfast Trust sent an email stating that the
14 reason for the transfer was due to the demands for
15 acute beds for female patients, and that Killead could 10:44
16 accommodate up to 21 patients. Essentially, the plan
17 involved a swap with male patients being moved out of
18 Killead Ward and into Cranfield.
19
20 I now understand that a risk assessment should have 10:44
21 been carried out for such a transfer. I have never
22 seen a document, whether for the plan as a whole or
23 specifically in relation to Alicia being moved in that
24 way. I was given no explanation that there would be
25 such a transfer. In ringing to enquire about Alicia's 10:45
26 wellbeing, I was then informed about the transfer
27 whilst it was ongoing. I cannot understand why the
28 transfer would not have been properly planned as it was
29 not an emergency response, or why it would take place

1 when H40, who was the consultant psychiatrist for the
2 patients, was away.
3
4 Before the move to Killead Ward, Alicia was doing
5 really well and she had been taken off her 10:45
6 antipsychotics. So far as I was concerned, Alicia was
7 getting to the point where she could be discharged. I
8 would describe the transfer as mayhem. The staff were
9 under pressure and the patients were unsettled. I
10 consider that P109 was not properly looked after due to 10:45
11 the chaos," **P109 being Alicia:**
12
13 "I was told afterwards by a nurse that the staff
14 members did not all know about the move. After the
15 transfer, I met H40 in the foyer of Killead Ward and 10:46
16 asked him what he thought of the move. He told me that
17 he had gone into Cranfield Ward when he returned from
18 leave and was quite alarmed to see a male patient in
19 the female ward. I was surprised that H40 did not seem
20 to be aware that such a transfer had happened while he 10:46
21 was away. This transfer is the subject of a complaint
22 that I made to the RQIA. Correspondence with the RQIA
23 on this and other complaints that I made, together with
24 minutes of meetings that I had with the RQIA, are
25 attached at Exhibit 6. 10:46
26
27 Killead Ward had 21 patients, which was more than in
28 Cranfield, and there was a shortage of staff. There
29 were new admissions who seemed to be in crisis, and a

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1 wider range of patients. All sense of normality in the
2 ward was gone. Alicia was not being properly protected
3 or cared for. Her hygiene was neglected, her teeth
4 were dirty, and there was an occasion where her
5 trousers fell and she was not wearing any underwear. 10:47
6 Alicia's brother-in-law visited Alicia at this time and
7 complained that she was very unkempt, which upset him
8 as this was not how she had previously been presented.
9
10 In the six weeks or more, there were lots of incidents 10:47
11 in Killead Ward with patient-on-patient attacks. In
12 one incident, Alicia was pushed by a patient and she
13 fell backwards onto the floor and banged her head. In
14 another, she was bitten on the hand twice within days
15 of each other by a patient. Many patients required 2:1 10:47
16 observation but this could not be provided due to
17 staffing shortages. When I went to Killead Ward to a
18 meeting with a nurse in charge, I heard a patient
19 screaming. I will never forget the awful sound. I was
20 worried about the impact of all this on Alicia. I was 10:47
21 told that Alicia was also hitting out.
22
23 There was no stimulation or activities for Alicia in
24 Killead Ward. I complained about staff about it. I
25 rang twice daily to enquire how Alicia had been and on 10:48
26 several occasions I asked if Alicia had been off the
27 ward. I was told that there was no enough staff to
28 facilitate this. At the time Alicia was a voluntary
29 patient and I thought of bringing her home, but I

1 believed that if I tried to do that, MAH would have
2 compulsorily detained her. H40 on one occasion told me
3 that if I attempted to remove Alicia from MAH, she
4 would be detained.
5 10:48
6 On 11th October 2016, about six weeks after the swap of
7 patients between Cranfield and Killead Wards, Alicia
8 was detained under Article 12 of the Mental Health
9 Order for treatment. I attended with Alicia with the
10 two doctors who were sections her. Alicia was telling 10:48
11 them that she had been hit and how she was repeating.
12 Alicia was trying to tell them in her own words how she
13 being treated. The doctors totally ignored her. I
14 asked for them to listen to her and to document what
15 Alicia was telling them, but they dismissed me. I want 10:49
16 the Inquiry to check if they ever bothered to document
17 this distressing incident.
18
19 I made a complaint to RQIA about Killead Ward and
20 Alicia's treatment, which I felt adversely affected 10:49
21 Alicia who had become increasingly agitated,
22 aggressive, and required PRN, and H40 had to introduce
23 a small dose of Seroquel even though Alicia
24 hallucinated when she was on it before. I think the
25 environment of Killead Ward and Alicia's response to it 10:49
26 all contributed to her being sectioned. Alicia was
27 talking about being afraid the day she was sectioned,
28 and at one point she tried to explain what was
29 happening to her to the two sectioning doctors but this

1 is not recorded in the assessment report. I requested
2 that they listen to what Alicia was saying and asked
3 them to record her words.
4
5 Alicia was admitted to PICU on or about 17th October 10:49
6 2016 under the supervision of H30. I believe that this
7 was shortly after I had made my complaint about Killead
8 Ward.
9
10 Alicia was not long in PICU when she was transferred 10:50
11 back to Killead Ward. I was told by H30 that it was
12 because another patient needed the place in PICU more.
13 At the time I believed there may have been some
14 benefits to Alicia being in PICU. There were a limited
15 number of patients; there was a higher ratio of staff, 10:50
16 and there was also psychology and art therapy. It took
17 some time before Alicia was provided with psychology
18 and art therapy. I had said I would assist Alicia's
19 move to PICU. I went up to help with the transition.
20 When we gained entry to the back of PICU, Alicia lay 10:50
21 down on the ground inside the floor. She lay down on
22 the floor in fear and submission. This incident
23 disturbed me greatly and I came away in tears worrying
24 about why she behaved like this. Looking back, I think
25 she was afraid of going back into the seclusion room. 10:50
26
27 When Alicia returned from PICU, she continued to be
28 affected by being on Killead Ward. On one occasion
29 Alicia was given the maximum level of PRN, 4mg of

1 Lorazepam, because she was so agitated even though she
2 was already on 27mg Diazepam. When I went to visit
3 Alicia at about 4:00 p.m. or 5:00 p.m. on the day, I
4 found her lying in bed comatose. I spoke to the senior
5 nurse and told her that was not how I expected Alicia 10:51
6 to be treated and it was unacceptable. I told the
7 nurse that my understanding was that PRN was a method
8 of the last resort. I was concerned that Alicia was at
9 risk of an overdose.
10 10:51
11 I complained to RQIA but they did not consider that
12 Alicia was at risk of an overdose. I cannot recall the
13 name of the person I spoke to, but she said that if
14 Alicia was on 27mg of Diazepam per day and given the
15 maximum PRN, this would have been fatal. She said that 10:51
16 Alicia was on 25mg per day, which was only 2mg off a
17 fatal dose.
18
19 In addition to these concerns, I had concerns about the
20 use of seclusion. I first became aware of it when H40 10:52
21 told me about a previous incident when Alicia was in
22 Cranfield Ward and had hit out at a nurse. H40 told me
23 that Alicia had been taken to a deescalation room for
24 about 15 minutes, and there was always a doctor with
25 her. He said this worked a treat. I thought this 10:52
26 would be a therapeutic room with someone to talk to her
27 about what had happened. I had no idea this might have
28 been the seclusion room. In fact, when Alicia was
29 admitted, I was not informed there was a seclusion

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1 room, what it was for or any procedures relating to its
2 use. It was only when I saw the seclusion room in 2016
3 that I thought back to what H40 had said, and realised
4 that it was the seclusion room that he said would work
5 a treat. I could not believe that this was what anyone 10:52
6 would think would work a treat, never mind a consultant
7 psychiatrist. I believe the seclusion room could only
8 instill fear and punishment, and it was a cruel,
9 inhumane practice which should never have been part of
10 a hospital. 10:53
11
12 I now find it difficult to accept this as being an
13 accurate description of Alicia's experience of the
14 seclusion room, and believe that it shows there was a
15 complete failure by all professionals and organisations 10:53
16 to recognise the impact it has had on her and others.
17 It was only after Alicia had subsequently been put in
18 the seclusion room while she was in PICU, and explained
19 to me what it was like, that I appreciated its true
20 impact. Alicia told me she had been put in jail, and 10:53
21 was really scared and that she was crying. I did not
22 press Alicia about this because I did not want to
23 distress and agitate her further."
24
25 **Then I'm going to pick up the reading at paragraph 83** 10:53
26 **over the page, where you say:**
27
28 "I asked H397, senior nurse at PICU, to show me the
29 seclusion room but he refused because he said there

1 were patients in the ward. I then asked Laura Waite
2 for assistance. She was able to arrange for H397 to
3 show me the seclusion room. I was brought through the
4 ward to visit the seclusion room. There was a door
5 beside the sensory tent which went down a dark corridor 10:54
6 to the seclusion room. I was shocked by what I saw.
7 The room was about three and a half foot wide and was
8 more like a cupboard. There was only a large leather
9 chair inside, which took up most of the room. The room
10 was very dark. There was no window. It was a dismal, 10:54
11 small, cold dark room and not therapeutic in any way.
12
13 H397 told me that sometimes a patient requested
14 time-out in the seclusion room to be alone, but I told
15 him that I could not imagine anyone asking to be put in 10:54
16 that room. I also told him that I could understand how
17 Alicia was so terrified from being in the room. H397
18 told me that CCTV was going to be put in the seclusion
19 room to protect patients and nurses from false
20 allegations. I asked how the patients get attention if 10:55
21 they need water, the toilet or felt unwell. I was
22 thinking particularly of Alicia, who had seizures.
23 H397 said that in those circumstances, they press the
24 buzzer. I pressed the buzzer but it was not working.
25 H397 then explained the buzzer was checked every week, 10:55
26 that there was always a member of staff outside the
27 door, and he said he had appreciated that the room
28 needed to be renovated, which he had discussed with
29 management.

1
2 The Belfast Trust assured me in a letter dated 17th
3 January 2018 that some of the issues I raised with the
4 seclusion room had been addressed, including ensuring
5 that the alarm is checked each time someone is in 10:55
6 seclusion. I was also told that there was no need for
7 an interlock system as there was always a member of
8 staff outside the room when a patient is in it. This
9 letter is included with the other Belfast Trust
10 correspondence in Exhibit 4. 10:56
11
12 I complained to the RQIA about the seclusion room when
13 they conducted an inspection in December 2016, and was
14 dissatisfied with the response. This inspection is the
15 subject of the RQIA Mental Health and Learning 10:56
16 Disability Inpatient Inspection Report of Cranfield ICU
17 dated 6th-8th December 2016. I understand that the
18 Inquiry already has this report. I also called the
19 Nolan Show about the seclusion room, and he did a piece
20 about it that was broadcast on 18th November 2018 which 10:56
21 featured an interview with H50. His explanations about
22 the reasons why a seclusion room was needed in MAH and
23 that it was a suitable environment were completely
24 unsatisfactory in my opinion. I would like the Inquiry
25 to listen to this broadcast, as the seclusion room was 10:56
26 entirely unfit for purpose and should have been done
27 away with.
28
29 On 11th April 2017, following Alicia's return from PICU

1 to Killead Ward, her detention was renewed under
2 Article 13(2) of the Mental Health Order for a further
3 six months. I went to see H40 to ask for Alicia to be
4 transferred to a quieter ward. Donegore Ward was
5 suggested, which is a smaller unit. There was 10:57
6 resistance to it for some time but she was eventually
7 moved to a three-bedroom ward at the back of Donegore
8 on or about 21st June 2017. I was pleased about the
9 move but unfortunately, the day afterwards, a patient
10 punched Alicia and stamped on her foot. Alicia was 10:57
11 there for a short period of time, and in that time
12 there were four or five incidents of Alicia being
13 attacked by two other patients. Alicia was then moved
14 to the larger area of Donegore. There was a patient
15 there who took a dislike to Alicia. 10:57
16
17 It was known by staff that this patient and Alicia did
18 not get on. According to the staff, on 28th May 2018
19 the same patient pulled Alicia's hair and kicked her,
20 leaving bruising to Alicia's right leg that I had to 10:58
21 query. There was meant to be two nurses there but
22 Alicia was clearly not being looked after. So,
23 ,although the ward was a very great improvement, the
24 care itself was lacking and a good opportunity to help
25 Alicia was being missed. I felt strongly that patients 10:58
26 have human rights that should be respected, and that
27 Alicia had a right to be kept safe and to be protected
28 from harm.
29

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1 I have made a series of complaints to MAH, the Belfast
2 Trust, and RQIA. At the time when Alicia was in MAH, I
3 was not made aware of the procedures for raising
4 safeguarding issues nor did I know how to do that. I
5 am now aware, and I believe that when I was complaining 10:58
6 about bruising and marks on Alicia's body and other
7 issues that I had about her care, these should all have
8 been treated under safeguarding. If they had followed
9 their own procedures, (let alone any improvements that
10 may be recommended), then in my view incidents of abuse 10:59
11 and lack of care would have been properly recorded and
12 might have made it harder for systematic abuse at MAH
13 to become so entrenched.
14
15 On numerous occasions I raised concerns and made 10:59
16 complaints about Alicia's care and treatment in MAH but
17 they were often not taken seriously or investigated.
18 On one occasion Alicia had bruising to the inside of
19 her wrist, and when I asked H397 what happened, he said
20 she might have banged it on a table. Given he did not 10:59
21 know, and I was raising an issue over it, I believe he
22 should have looked into it further, but he did not.
23 Two days or so later an older nurse, H89, asked me if I
24 had heard about Alicia, that she had pulled a baguette
25 out of H570, another staff member's hand, and at this 10:59
26 H89 started to laugh. I walked away confused as I did
27 not know why she was telling me about that, but I
28 thought after she had maybe heard about me questioning
29 the bruising on Alicia's wrist and was therefore trying

1 to make light of it, as that incident with H570 was how
2 Alicia had actually ended up with the bruising.
3
4 I refer particularly to a complaint I made on
5 23rd November 2015 about the handling of Alicia's 11:00
6 adverse reaction to Lamotrigine. There was a meeting
7 with H40 on 23rd May 2016 to discuss it. Whilst I do
8 not have notes of this meeting, it is referred to in
9 the 3rd June 2016 letter from the Belfast Trust that I
10 have included as Exhibit 4 along with other 11:00
11 correspondence with Belfast Trust. I also refer to
12 minutes of meetings I had with Belfast Trust that are
13 attached at Exhibit 7.
14
15 H40 did not acknowledge that there was an issue. He 11:00
16 said that when Alicia was discharged, the rash was only
17 on her hands and that H338 had not got up that morning
18 to do any harm. He did not listen to me and did not
19 accept that harm had happened. H40 said that when it
20 was on Alicia's hands, it presented as scabies. The 11:01
21 social worker, H554, who was also present, confirmed
22 that she was helping Alicia go to the day centre and
23 she saw the rash, which was on Alicia's hands and arms
24 when she was discharged.
25 11:01
26 I was completely dissatisfied with H40's response and I
27 made a formal complaint with Musgrave Complaints
28 Department. As a result, there was a further meeting
29 involving H40, H50 and someone from the Complaints

1 Department.

2

3 Prior to that meeting, I found out that H33 had only
4 been training for three years. During the meeting, I
5 specifically asked who was overseeing him when H40 was 11:01
6 away and that someone senior should have been. I
7 referred to the risks associated with Lamotrigine
8 including Stephens Johnson Syndrome, and considered
9 H338 should have been properly advised about it. H50
10 apologised several times during the meeting and said 11:02
11 that he should have been overseeing H338. H40 said
12 that the learning from this would be that I was not
13 listened to, but he did not apologise. However, I
14 consider that an additional learning should have been
15 that if there is a potentially very serious adverse 11:02
16 reaction to medication, this should be highlighted so
17 that any doctor looking after the patient can be aware
18 of it and the symptoms to look out for. I think that
19 also think that H40 had a responsibility to ensure this
20 was done before leaving on holiday. I cannot 11:02
21 understand how it was thought appropriate to warn me
22 but not the doctor taking care of Alicia in his
23 absence.

24

25 I received the letter from Belfast Trust dated 3rd June 11:02
26 2016 assuring me that there was appropriate supervision
27 in place and that my experience would be shared at the
28 doctors' monthly teaching session. It was also agreed
29 that there would be an audit to identify and quantify

1 the need for doctors in MAH to access outside
2 specialists. This letter is included as part of the
3 correspondence from Belfast Trust included in Exhibit
4 4. I have not seen any evidence that an audit was ever
5 carried out and I would like the Inquiry to investigate 11:03
6 whether such audits were carried out and whether a
7 protocol or guidance was developed for MAH doctors to
8 have access to specialist independent opinion, as they
9 refused that for Alicia and instead went to another
10 consultant psychiatrist employed by the Belfast Trust. 11:03
11
12 I was not satisfied with the treatment of my complaint
13 and subsequently I spoke to Billy Moore at the Society
14 of Parents and Friends of Muckamore. He recommended
15 that I contact a solicitor. I did speak with a 11:03
16 solicitor who was sent a pre-action protocol letter in
17 and about June 2018 about Alicia's epilepsy medication
18 and antipsychotic medication. By this time, there were
19 other issues concerning the management of Alicia's
20 medication that were being raised which I considered 11:04
21 contributed to a deterioration in Alicia's condition
22 and her detention under the Mental Health Order on
23 11th October 2016 for about a year until 25th September
24 2015. However, I did not want to pursue litigation
25 because Alicia was still in MAH and under their care 11:04
26 and I was concerned that they had all the power, and I
27 was worried about the repercussions on Alicia if I made
28 a complaint.
29

1 I was invited to meetings to discuss issues and to
2 receive updates on 27th October 2016, 18th November
3 2016, and 2nd February 2017. The minutes of these
4 meetings were taken by MAH. I have included these
5 minutes in Exhibit 7. 11:04
6
7 These meetings included H30, consultant psychiatrist,
8 H397, and others, and I attended with Laura Waite.
9
10 Whilst these meetings were a good idea in principle, I 11:05
11 found them frustrating and unsatisfactory as they
12 seemed to make no difference, apart from allowing MAH
13 to say that I had been given an opportunity to raise
14 any concerns. Examples of these meetings making no
15 difference include the lack of any resolution to the 11:05
16 fundamental issues of treating Alicia with
17 antipsychotics, despite the evidence of her increase in
18 seizures; moving her on to Killead Ward and returning
19 her back there, despite it being known that she reacted
20 very badly to that environment and did not do well; 11:05
21 helping her to move out of MAH and providing the
22 necessary supports. I feel that the impact of hope was
23 not really addressed and that Alicia was in a vicious
24 cycle. She reacted badly to the antipsychotics and the
25 ward environment, the chances of getting discharged 11:05
26 receded, she reacted badly to that and was put on other
27 antipsychotics. There seemed to be no proper pathway
28 that allowed Alicia to see how she would get out of
29 MAH.

1
2 I will felt that I had to be constantly on alert to
3 protect Alicia and I felt that MAH should be ensuring
4 that Alicia was kept safe and was not harmed by the
5 medications they gave her. Despite the evidence over 11:06
6 so many years that antipsychotics led to increases in
7 Alicia's seizures, MAH still persisted in trying out a
8 series of them. I tried to raise my concerns that not
9 only were increases in her seizures damaging and
10 destabilising, taking time for Alicia to settle, but 11:06
11 they might also interact badly with her tuberous
12 sclerosis and increasing the brain damage and kidney
13 function. It is worth pointing out that Alicia was
14 constantly presenting with bruises in this period.
15 11:06
16 Even when MAH finally agreed to obtain a second
17 opinion, they refused to seek one from English experts
18 in tuberous sclerosis and mental health and who could
19 bring an independent view, but chose to go to H553, a
20 consultant psychiatrist employed by the Belfast Trust. 11:07
21 This was despite it being acknowledged that there was
22 no one in Northern Ireland with expertise and
23 experience in tuberous sclerosis and mental health,
24 which led me to believe that MAH did not really want
25 anyone who might challenge what they were doing with 11:07
26 Alicia.
27
28 The opinion letter report from H553 dated 9th June
29 2017, essentially concluded that Alicia's case was very

1 complex, and treatment needed to incorporate her
2 comorbid physical problems, psychiatric symptomology,
3 history of trauma and social environmental factors.
4 Notwithstanding that, Alicia's Haloperidol was slightly
5 increased. I was unable to see how H553's comments 11:07
6 were factored into Alicia's treatment plan, for example
7 his reference to her history of trauma and
8 social/environmental factors.
9
10 Inaccuracies in Alicia's notes and records was a 11:08
11 continuing problem. I felt that they could be biased,
12 and this was a worry as they represented the accepted
13 record on which decisions would be made and could have
14 a detrimental effect on her at day care. The meeting
15 of 27th October 2016 was a rare admission of 11:08
16 inaccuracies where it is recorded that H556, ST5 at
17 MAH, apologised for the confusion and miscommunication,
18 and H30 also apologised on behalf of the
19 multidisciplinary team. This is one of the minutes I
20 have included in Exhibit 7. It is not possible for me 11:08
21 to be checking the accuracy of Alicia's medical notes
22 and records, they should be correct in the first place.
23 I have concerns that they are not correct and worry
24 about this because some of the staff are currently
25 charged with criminal offences. 11:08
26
27 There were reports from RQIA on Cranfield Ward for each
28 year that Alicia was in there, i.e. 2015, 2016, 2017
29 and 2018. I raised numerous concerns over Alicia's

1 care in those years. I understand the Inquiry already
2 has access to those RQIA reports into MAH and I invite
3 the Inquiry to consider those for the years of Alicia's
4 admissions. In addition to carrying out unannounced
5 visits to PICU, RQIA also visited Killead Ward while 11:09
6 Alicia was there. My carer's advocate helped me make
7 complaints to RQIA.
8
9 From 2016 I was raising concerns with RQIA,
10 particularly about the seclusion room, and these 11:09
11 complaints did not end up in the reports. I remember
12 an inspection conducted by RQIA from 6th-8th December
13 2016. I explained in detail to the inspector the fear
14 and trauma that Alicia had experienced by being placed
15 in the seclusion room. I also told her about the 11:09
16 inappropriateness of the room for so-called
17 deescalation, and the fact that the buzzer was not
18 working. I asked if the inspector had seen the
19 seclusion room. She did not answer at the time. I
20 said that someone needed to do something about it, and 11:10
21 it was not fit for purpose. RQIA made a report from
22 the inspection but there was no mention about the
23 seclusion room. Laura Waite and I could not believe
24 this when the report came out.
25 11:10
26 I spoke to an RQIA staff member at an RQIA consultation
27 with regards to delayed discharge patients on
28 21st November 2017. I have included an RQIA
29 questionnaire that I completed on delayed discharge in

1 Exhibit 8, along with RQIA notes of my meetings with
2 them, and complaints documents. I spoke to her about
3 the inspection of the seclusion room. I attended this
4 meeting with other parents and Laura Waite, my
5 advocate. I recall another mother called Tara, and she 11:10
6 was raising concerns about her daughter's care in
7 Killead.
8
9 RQIA did not speak to Alicia during the inspection. I
10 asked the RQIA staff member to assure me that what she 11:11
11 had heard on that day from all the parents was included
12 in her report. It was clear that the room that they
13 had been shown was not the same room that I had been
14 shown. The report from RQIA was not published. In a
15 telephone conversation between myself and the RQIA, an 11:11
16 RQIA staff member", **who you name,** "told me she was told
17 by her seniors to stand down from the report. She told
18 me that the reason she was given was that the
19 consultation had changed in format and it was not just
20 focused on delayed discharge patients in MAH. I want 11:11
21 to know why there was no report done by the RQIA
22 despite the fact there were so many concerns raised by
23 families on this date. As a result, I made a complaint
24 on or about 25th June 2018, which led to a
25 clarification meeting on 8th August 2018 that I 11:11
26 attended with Laura Waite.
27
28 RQIA provided their draft and final notes of the
29 clarification meeting in Exhibit 6. It records that I

1 again asked whether they had seen the seclusion room,
2 and said that in my view someone needed to do something
3 about it as it was not fit for purpose and Alicia had
4 been very traumatised by it. During the discussion the
5 inspector claimed to have seen a mattress on the floor 11:12
6 in the seclusion room, which did not fit with the
7 seclusion room I had seen in 2016. I asked whether the
8 photographs of the room were taken and was told they
9 were not. I was instead shown photographs of a
10 therapeutic room. 11:12
11
12 I do not think RQIA ever went and inspected the
13 seclusion room at this stage. The note also records
14 that the Director of Improvement/Medical Director asked
15 me how I would have liked the RQIA to have responded to 11:12
16 my conversation with the inspector, to which I replied
17 that the room was clearly not fit for purpose which is
18 why I had raised it in 2016, and that I would have
19 expected the room to have been dealt with at that time.
20 11:13
21 So far as I was concerned, it was a highly
22 unsatisfactory meeting. Laura Waite pointed out that
23 MAH was transforming the seclusion room having
24 recognised that changes were needed. It was clearly
25 not fit for purpose in at least 2016 when the RQIA 11:13
26 inspected it, so the issue is why RQIA had not seen
27 that and reported on it. I regarded that as a failed
28 opportunity to identify the inaccuracy of the seclusion
29 room much earlier which could have prevented other

1 parents from having to experience it.
2
3 I am aware that the Inquiry was shown photographs of
4 the seclusion room at the outset of the public hearings
5 as it is now and not how it was. I would like the 11:13
6 Inquiry to obtain photographs of the old seclusion room
7 before it was done up which I believe they should be
8 able to obtain. Perhaps the Belfast Trust, MAH
9 archives or police may have these.
10 11:13
11 I refer to subsequently overhearing P118, who was a
12 patient in MAH and had an apartment in a facility"
13 **which you name** "about Alicia's calling out not to be
14 put in the 'black hole'. I knew immediately that it
15 was a reference to the seclusion room and I mentioned 11:14
16 it to staff at the other facility and asked for it to
17 be passed on to P118's mother. I am also aware from my
18 involvement with Action for Muckamore and Glynn Brown
19 that his son had to endure the seclusion room, and I
20 believe that many more could have been spared the 11:14
21 horrific experience if RQIA had done its job properly.
22
23 There another meeting on 8th November 2018 that was not
24 much better. I have included RQIA notes of this
25 meeting in Exhibit 6. I explained that I had completed 11:14
26 a complaint agreement pro forma which included a
27 summary of my complaint and what I hoped to achieve. A
28 copy of this is in Exhibit 6. The sole result was a
29 change to the report to add 'The inspector agreed with

1 Catherine that at the time of the inspection Catherine
2 had informed her that Alicia had referred to her time
3 in the seclusion room as staffing putting her in
4 prison'. That was incorrect and it should have been
5 'jail' as recorded in RQIA's notes of the 8th November 11:15
6 2018 meeting.
7
8 I persisted with my complaint, which was then
9 escalated. Eventually in a letter dated 1st April
10 2019, RQIA apologised for the whole process of dealing 11:15
11 with my complaint, upheld part of it and recommended
12 that the RQIA simplify its complaints process and make
13 reasonable adjustments for patients with mental
14 ill-health to ensure their views are captured in
15 inspection reports. This letter is included in 11:15
16 Exhibit 6.
17
18 I would like the Inquiry to investigate exactly when
19 the RQIA first inspected the seclusion room, what they
20 recorded about that inspection and what, if anything, 11:15
21 did they recommend should be done with it? There is a
22 real issue of trust, and as far as I could see the RQIA
23 worked hand in hand with Belfast Trust and they all
24 covered up for each other, as I cannot think of any
25 other reason why RQIA failed to see and report on what 11:16
26 should have been obvious.
27
28 I also want the Inquiry to investigate whether RQIA
29 have simplified its procedures and made reasonable

1 adjustments. Not only was there no real incentive for
2 families to help the RQIA as a regulator, even when
3 they did complain, as I did on several occasions,
4 little came of it. In my view they failed as an
5 effective regulator. I believe that due to the 11:16
6 complexity and unsatisfactory nature of the process,
7 the RQIA failed to properly protect the interests and
8 rights of vulnerable people when it could have done so,
9 and that in my view led to avoidable harm being done.
10 11:16
11 I wanted to take Alicia home and have arrangements for
12 supports and respites to be put in place. The social
13 worker said this would not be possible and that my
14 house would be chaos and that Alicia would need her own
15 place. My understanding from the Belfast Trust was 11:17
16 that I would have to tell the Northern Ireland Housing
17 Executive that Alicia was homeless. I told them that I
18 could not do that. Alicia was my daughter, and she had
19 a home with me. The alternative was to have Alicia
20 discharged into supported living accommodation when she 11:17
21 was sufficiently well. I viewed a few places..."
22
23 Chair, I'm being asked if we can take a little break.
24 CHAIRPERSON: Do you need a break?
25 THE WITNESS: A short break, please. 11:17
26 CHAIRPERSON: Yes, okay.
27 MS. KILEY: There's not too much reading left but
28 perhaps if we could --
29 CHAIRPERSON: There's about five minutes to go.

1 THE WITNESS: I won't be long.
2 CHAIRPERSON: We'll just stop. We'll just sit here,
3 actually. I'm not going to rise because we'll take a
4 proper break afterwards.
5 11:17
6 SHORT PAUSE IN THE PROCEEDINGS
7
8 CHAIRPERSON: Are we all right to carry on?
9 MS. KILEY: Yes, thank you, Chair. Are you happy
10 enough to continue, Catherine? 11:25
11 CHAIRPERSON: We'll take another break in a few minutes
12 once the statement is finished anyway.
13 THE WITNESS: Okay, thanks.
14 MS. KILEY: Chair, I'm told that a ten-minute break
15 would be welcomed on that occasion; at least ten 11:25
16 minutes.
17 CHAIRPERSON: It will be longer than that.
18 4 Q. MS. KILEY: Catherine, I'm going to pick up the reading
19 halfway through paragraph 116, where you say:
20 11:25
21 "The alternative was to have Alicia discharged into
22 supported living accommodation when she was
23 sufficiently well. I viewed a few places and chose a
24 facility", which you name, "because it looked homely
25 and there was an open door policy, which was vitally 11:25
26 important to me due to the experiences of Alicia being
27 locked in MAH.
28
29 A risk management plan was prepared for Alicia in June

1 2018 prior to her discharge from MAH and being placed
2 in", **that other facility which you name.** "I have
3 included this risk management plan in Exhibit 9. I
4 believe that a risk management plan should have been
5 prepared for each of Alicia's moves within MAH. 11:26
6
7 Alicia was discharged from MAH in or about July 2018."
8
9 **For the rest of paragraphs 118 and 119, you explain**
10 **some of your concerns about safeguarding in the** 11:26
11 **community. I'm going to pick up the reading then at**
12 **paragraph 120, where you say:**
13
14 "I do, however, want to make it clear that I am aware
15 of good caring staff, not just in the community but in 11:26
16 MAH. In my view having interacted with staff in
17 relation to Alicia over a number of years, these good
18 staff need to be properly valued and helped with better
19 training and improved terms and conditions. They also
20 need to be encouraged to be part of improving the 11:27
21 system whether it is in MAH or in the community. With
22 the appropriate training and support, staff can be part
23 of ensuring that procedures are followed and those who
24 are not conducting themselves properly are made
25 accountable. My experience is that not only do some 11:27
26 staff not know how to properly raise concerns but many
27 who do may be afraid to do so."
28
29 **Then I'm going to move to paragraph 122, where you say:**

1
2 "Alicia continued to be on Haloperidol after she was
3 discharged were MAH. In October 2019 she was admitted
4 to hospital with a grand mal seizure which was
5 life-threatening. The consultant neurologist told me 11:27
6 that 50% of the patients he treated where seizures,
7 those seizures were related to antipsychotic drugs. He
8 took Alicia off the antipsychotics because of this
9 seizure.
10 11:27
11 I deeply regret ever having Alicia admitted to MAH.
12 I believed as a hospital, it would help her and keep
13 her itself. I believe that the stubborn refusal to
14 consider any alternative to the antipsychotic
15 medication, even though they knew her case was 11:28
16 particularly complex and no one there had real
17 expertise and experiences in treating patients with
18 tuberous sclerosis and mental health issues inflicted
19 damage on Alicia. A senior manager said to me at MAH
20 prior to Alicia's discharge at a meeting that if what 11:28
21 happened to Alicia, the assault happened now, she would
22 never have been admitted to MAH.
23
24 I believe that they robbed Alicia of her capabilities
25 and instead of helping Alicia with her difficulties, 11:28
26 they regressed her. Alicia was not helped to deal with
27 some of the trauma she experienced in the community,
28 which was compounded by the abuse which she suffered in
29 MAH. As a result of her time in MAH, Alicia has been

1 left with fearful recollections and permanent scarring
2 from her adverse reaction to the Lamotrigine, and she
3 is far from the person she once was before entering
4 MAH.
5 11:29
6 I would like the Inquiry to investigate the extent to
7 which MAH should have provided effective wraparound
8 care and treatment, addressing their parents' mental,
9 medical and behavioural issues in a coordinated way. I
10 would also like the Inquiry to investigate the extent 11:29
11 to which this care should have been properly extended
12 into the community when patients were discharged to
13 give their placements the best chance of success and
14 them the best chance of being content.
15 11:29
16 I remain concerned about Alicia's long-term psychiatric
17 care and would like the Inquiry to recommend that the
18 Belfast Trust fund an independent assessment and report
19 on Alicia's medication and the treatment plan going
20 forward. 11:29
21
22 Alicia is now in Stage 5 kidney failure and is on the
23 transplant list. I would question whether Alicia's
24 renal failure is connected to the medication she was
25 prescribed long-term, and possibly unnecessarily whilst 11:29
26 in MAH. Her brothers and uncles have come forward as
27 potential donors. Thankfully one of my brothers is a
28 match, and the process is in the final stages before he
29 can donate a kidney to Alicia. I am in awe of my

1 family and their love towards Alicia and I just now
2 pray to God that everything goes well."
3
4 And, Catherine, that's the end of the section that I'm
5 going to read out. I just have one question for you 11:30
6 before I let you take the break. That is, having heard
7 me read that out, are you content that the statement is
8 accurate and do you wish to adopt that as your evidence
9 today?
10 A. Yes. 11:30
11 MS. KILEY: Okay.
12 CHAIRPERSON: So, the next part of the process, after
13 the break, will be that Ms. Kiley will just look at a
14 couple of areas of this statement that she wants to
15 explore with you orally, and then the Panel will also 11:30
16 have a chance to ask you any questions, and then you'll
17 be given the chance to say anything that you want to
18 say. So, that's the process that we're going through.
19 We'll take a break now. We'll take a bit longer than
20 15 minutes. We'll try and come back just after ten to 11:31
21 12. All right? Okay. Thank you very much.
22
23 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
24
25 CHAIRPERSON: Thank you very much. 11:54
26 MS. KILEY: Chair, just for information, I have spoken
27 to the witness during the break about breaks and she
28 has indicated that she would like, if possible, to have
29 a short break after I finish my questioning and before,

1 perhaps, the Panel have any questions so that she can
2 gather her thoughts and make sure she has --
3 CHAIRPERSON: Of course.
4 MS. KILEY: I anticipate that I will be, hopefully,
5 half past 12. 11:55
6 CHAIRPERSON: What we might do then is take an early
7 lunch, take a break then and give you a chance to have
8 a bit of a think and then we'll carry on. Thank you.
9 5 Q. MS. KILEY: As you know, Catherine, you've heard your
10 statement being read, and you have provided a lot of 11:55
11 detail in that so I'm not going to ask you to go over
12 every single thing again, but there are a few things
13 that I want to pick out just to ask you a little bit
14 more about. Okay?
15 A. Okay. 11:55
16 6 Q. The first thing is about Alicia's diagnosis. You have
17 described a series of complex medical conditions which
18 Alicia has?
19 A. Mmm.
20 7 Q. But I want to ask you particularly about the diagnosis 11:55
21 of a moderate intellectual disability. When was that
22 diagnosis made?
23 A. From what I recall in the Maureen Sheehan Centre, in or
24 around 11.
25 8 Q. Aged 11. 11:55
26 A. They done some sort another test.
27 9 Q. Can you describe to the Panel how that particular
28 disability affects her on a daily basis?
29 A. Her learning disability?

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1 10 Q. Yes.
2 A. I would say Alicia is very astute and, you know, smart
3 in many ways. But academically, you know, I always
4 realised she was never going to reach her potential
5 academically. But Alicia's amazing because she could 11:56
6 be sitting, we could be chatting, maybe me and me
7 family or others, thinking she's not listening and then
8 she could repeat everything to you. I always thought
9 she was quite capable in many ways, especially when she
10 was younger and before Muckamore. 11:56
11 11 Q. And how are her communication skills?
12 A. Presently not good.
13 12 Q. Okay.
14 A. I do suspect that the several episodes of grand mal
15 seizures and static epilepsy, I'm in no doubt that it 11:57
16 has done her, which I believe, brain damage. So, in
17 the past she would have been able to sit and have a
18 conversation. Now, how she presents is if she starts
19 to talk about one subject, it sort of runs into another
20 subject. It's almost as if, to me, she's getting 11:57
21 confused. Then there's other times out of the blue she
22 can be quite compos mentis. I mean, I don't know, I'm
23 not an expert, I'm her mother - well, I am an expert
24 actually, I am her mother - but definitely she is not
25 the same, she doesn't have the same abilities that she 11:57
26 used to have.
27 13 Q. And you raised a number of concerns, you heard me read
28 them out, about medication in your statement?
29 A. It's a well-known medical fact that antipsychotics will

1 lower the threshold of epilepsy.
2 14 Q. I'm going to come to ask you a little bit about that
3 because you have concerns about antipsychotics and
4 other medicine episodes in MAH, so I will ask you a
5 little bit about that. You described a number of 11:58
6 admissions to Muckamore?
7 A. Yes.
8 15 Q. Five, I counted in all, over between November 2008 and
9 August 2018?
10 A. Yeah. 11:58
11 16 Q. I want you to think about those earlier admissions just
12 for a short time, because in your statement you
13 described the first admission, which was 6th November
14 2008, and that occurred after an assault in the
15 community. You also described a later admission which 11:58
16 took place on 8th February '18; that was the admission
17 shortly after your mother died?
18 A. Mm-hmm.
19 17 Q. When you were discussing both of those in your
20 statement, you described how you felt that Alicia 11:58
21 needed therapeutic help on those occasions and how you
22 thought that that's what she would get in Muckamore.
23
24 Can you tell us, thinking about those earlier
25 occasions, did Alicia receive any psychological input 11:59
26 during those admissions?
27 A. Never.
28 18 Q. Was it ever explained to you why that didn't happen?
29 A. No, to be quite honest.

1 19 Q. You did, later, describe one occasion in October 2016
2 when Alicia was admitted to PICU, and you say she got
3 psychological input and art therapy then. Was that the
4 first time that she got that sort of treatment?
5 A. I'm not even a hundred percent sure it was 11:59
6 psychological treatment but I do know she got more
7 support. There was an art therapy, she done a bit of
8 art, and there was a lady that I presumed that's what
9 she was and she, you know, helped her. No great detail
10 was ever given to me or... 12:00
11 20 Q. Were you ever told about a behavioural support plan or
12 anything like that that was created for Alicia?
13 A. No, not at that time. I would understand that now.
14 21 Q. Yes.
15 A. But no, I would never even have heard those words 12:00
16 probably back then.
17 22 Q. Just to be clear, does that extend to her whole time at
18 Muckamore then, the behavioural support plan? When did
19 you get some knowledge about that?
20 A. Only after, in recent years, I educated myself within 12:00
21 the community. Definitely, definitely never heard
22 those.
23 23 Q. Okay.
24 A. Or was it offered in Muckamore.
25 24 Q. But she did get some access to day centre in Muckamore? 12:00
26 A. Yes.
27 25 Q. Can you tell us a little bit more about that? Do you
28 know what sort of treatments or therapy she had access
29 to there?

1 A. It would have been Alicia going over to the day centre,
2 maybe doing a bit of art, maybe doing a bit of cooking,
3 music. But that would have been it.
4 26 Q. Okay. The longest admission that Alicia had was the
5 one that was between 7th November 2015 and 13th August 12:01
6 2018?
7 A. Yes.
8 27 Q. When you referred to that in your statement at
9 paragraph 52, you said that that was the time that
10 several serious incidents arose. You describe them as 12:01
11 "Errors with medication that led to a serious adverse
12 reaction, mismanagement of transfers to other wards,
13 and the handling of complaints".
14 A. Mm-hmm.
15 28 Q. Later in your statement when you are discussing that 12:01
16 admission, you also refer to concerns about seclusion
17 and bruising?
18 A. Mm-hmm.
19 29 Q. I want to take each of those topics and just ask you a
20 little bit about each of them. 12:02
21 A. To be clear, from all of Alicia's time in Muckamore,
22 even the short first stay, there was bruising then.
23 That's continued no matter at what stage she went in
24 and no matter what ward she was in. There was constant
25 bruising. 12:02
26 30 Q. Okay. So perhaps that's a good one to start with then.
27 A. Mm-hmm.
28 31 Q. So, that's something that you said you noticed
29 throughout her stays. Can you tell the Panel a bit

1 more about where you noticed bruising on Alicia; how
2 severe it was?
3 A. When she first went in, the first short stay in
4 Cranfield - to be honest I can't remember the year now
5 - there was bruising on her arms. Alicia referred 12:02
6 to -- said to me - and at that time she would have been
7 quite able to talk and explain things - and she said
8 that the nurses were cheeky to her, that another
9 patient were hitting her and nipped her. I would have,
10 you know, raised the concerns because I expected, it 12:03
11 was a hospital, I expected that Alicia would be cared
12 for and protected, you know.
13
14 And then the second time that she was in, you know, it
15 was the same thing. Bruising. You know, it could have 12:03
16 been on her leg, it could have been on her arms.
17 Alicia would have been telling me that she was being
18 hit. But it wouldn't have been as much -- it wouldn't
19 have been happening as much at that point, you know.
20 Her first admission, her second admission, it wouldn't 12:03
21 have been having, what I would call abuse, wasn't
22 happening as often, or her injuries.
23 32 Q. When you say that you reported them, you reported those
24 incidents, I don't want you to name names but if you
25 can tell us by perhaps reference to their role, who 12:04
26 would have you reported those things to on?
27 A. So, nurses and senior staff. I would have said, like,
28 why is Alicia bruised or why isn't she being protected,
29 and this shouldn't be happening. You know, obviously I

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1 was deeply concerned and Alicia was upset by it. So,
2 of course as a mother I raised those concerns.
3 33 Q. And that was raised verbally, was it?
4 A. Yeah, uh-huh.
5 34 Q. What responses did you get? 12:04
6 A. Usually the response would be, oh, there was incidents
7 on the ward, and it was another patient and, you know,
8 we used intervention and that was the reasons for the
9 bruising and injuries on Alicia.
10 35 Q. How satisfied with those responses were you? 12:05
11 A. Not satisfied whatsoever. But, you know, I would not
12 have been aware of how a complaints process would have
13 worked; I wouldn't have understand that there was a
14 safeguarding process. I do realise now. Me raising
15 concerns should have brought to the attention of the 12:05
16 social worker, an APP1 then should have been begun; I
17 should have been spoke to; it should have been
18 investigated; it would have went through a process
19 under and reached APP7; I should have been involved in
20 all of that. I didn't know that back now, I know it 12:05
21 now. It never happened. I felt that there was almost
22 like there was this attitude that that's the norm up
23 here, people end up black and blue. Honestly, that's
24 the truth. It was almost as if there was an acceptance
25 that these sort of things happened here. But I could 12:06
26 never accept that so I was continuously, you know,
27 objecting and raising concerns, but they weren't being
28 listened to.
29 36 Q. Whenever you were raising those concerns, I know you've

1 said that you weren't aware of the complaints process,
2 but when you were raising those concerns verbally with
3 staff, were you ever told that there was a formal
4 complaints process you could go through?
5 A. No. 12:06
6 37 Q. Do you ever recall at the time, for example, seeing
7 posters or anything of that kind in the hospital that
8 explained complaints processes?
9 A. Never.
10 38 Q. No. Were you -- 12:06
11 A. I wasn't even, sorry, aware that, you know, there was
12 advocates or anything like that. Nobody ever explained
13 anything like that.
14 39 Q. That's just what I was going to ask you about actually.
15 Were you ever aware about the PCC, the Patient Care -- 12:07
16 A. Never heard tell of them. Honestly, never.
17 40 Q. Okay. The other topic that I wanted to ask you about,
18 which you discussed in detail in your statement, was
19 the allergic reaction that Alicia took to the
20 Lamotrigine. 12:07
21 A. Mm-hmm.
22 41 Q. You have provided great detail about that in your
23 statement and I'm not going to ask you to go over that.
24 A. Yeah.
25 42 Q. But I wanted to give you an opportunity to explain a 12:07
26 little bit more. You were clearly dissatisfied at the
27 responses you got whenever you raised issues with the
28 various people who you've described in your statement.
29 What do you think that Muckamore staff could have done

1 at the time to prevent that allergic reaction
2 happening?
3 A. Well, I would have expected that they would have called
4 in a doctor. I think the mere fact that Lamotrigine --
5 and I'm not sure if I'm producing it right. 12:08
6 43 Q. You probably are, I'm probably not.
7 A. Lamotrigine, because it came with a high risk and a
8 life-threatening risk, you know, and the fact that
9 Dr...
10 44 Q. Don't worry. Take your time, and the cipher list is 12:08
11 there?
12 A. H40, you know, had explained to me one in so many could
13 take a severe allergic reaction. Catherine, he said,
14 if that happens, if she comes out in a rash, she needs
15 to be brought to the Antrim Area Hospital, and in 12:08
16 fairness he had given me that warning. So, therefore,
17 how would I have liked them to have reacted? So
18 because there was this risk, in my mind that's the
19 first thing I would have ruled out. I wouldn't have
20 thought scabies, I'd have went to the top and by 12:09
21 elimination I'd have said I need to rule out that this
22 isn't connected to the medication. I couldn't
23 understand the way that that -- I forget his name, what
24 do you call him? Sorry. I couldn't understand how
25 H338, his approach was, instead of by elimination, the 12:09
26 most risky reaction to the tablets, I felt.
27
28 In my opinion what they should have done -- in fact not
29 even my opinion, what they should have done, they

1 should have contacted a GP; they should have took her
2 over to Antrim Area Hospital; her blood should have
3 been taken; it should have been ruled out that the
4 reaction was not related to the tablet, because they
5 needed to protect her. 12:10
6 45 Q. Yes.
7 A. And they failed, failed, failed. Then whenever, you
8 know, Alicia was discharged, and God bless her, she was
9 delighted to be home and, you know, her form was good.
10 You know, this was on her hands, it was on her arms, it 12:10
11 was spreading over her body, you know. Even though I
12 knew it wasn't the scabies, I was doubting myself and
13 saying, God, maybe they're right. Got the -- phoned
14 the GP, got the antihistamine. I remember making the
15 supper that evening, we were sitting, I gave her the 12:11
16 antihistamine. Within half an hour, she began to
17 behave bizarrely. She was hallucinating, she was
18 saying things like oh, I think something is happening
19 to my brother and, you know... I knew it wasn't mental
20 health sort of, it was just strange. 12:11
21
22 So, as I said in my statement, we took her to the Royal
23 Victoria Hospital. I do believe, because she'd only
24 been discharged from Muckamore, that they were probably
25 thinking it was more mental health. I don't know even 12:11
26 think they took a blood test.
27
28 I often wonder, sorry, I know it was called PARIS back
29 in the day, it's now ACR, but I often wonder had

1 Muckamore put up on PARIS that she was on Lamotrigine,
2 because, you know, why did the hospital not take her
3 bloods? Do you know what I mean? Because they surely
4 should have recognised that Lamotrigine had a risk of,
5 what do you call it, having a severe allergic reaction. 12:12
6 Certainly in hindsight it confused me, why didn't the
7 Royal Victoria Hospital take her bloods.
8 46 Q. When you refer to PARIS, they are the electronic note
9 keeping?
10 A. Did Muckamore have it up on PARIS that Alicia was 12:12
11 actually on Lamotrigine?
12 47 Q. You described H40 warning you of the possibility of an
13 allergic reaction?
14 A. Yeah.
15 48 Q. Was that something that he did verbally or -- 12:12
16 A. Verbally, yeah.
17 49 Q. -- did he write anything down. Okay.
18
19 Was that at a meeting or just during a conversation?
20 A. No, no. I think it was standing in the foyer and he 12:12
21 explained that to me, yeah.
22 50 Q. Okay. Was there anyone else there during that
23 conversation?
24 A. No.
25 51 Q. Okay. You described Alicia as having permanent 12:13
26 scarring as a result of that reaction?
27 A. Mm-hmm.
28 52 Q. Can you tell us a little bit more about that?
29 A. So, besides the facial rash, which is characteristic of

1 or can be characteristic of tuberous sclerosis, Alicia
2 had pretty good skin, never really had acne or
3 anything. But in the aftermath of the severe allergic
4 reaction, she developed boils under her breasts and her
5 groin, warm areas. It still continues and it causes 12:13
6 her an awful lot of discomfort and pain.
7 53 Q. Is she still getting treatment for that?
8 A. Yes, she is.
9 54 Q. That episode, I think, is possibly also linked to one
10 of the other issues you raised which is handling of 12:13
11 complaints, because you have described how you
12 complained about that episode, and we have heard that
13 in your. You said that in making complaints about
14 that, you didn't think that you were being taken
15 seriously; is that right? 12:14
16 A. Yeah.
17 55 Q. Can you explain a little bit more about why you felt
18 that way?
19 A. What are you referring to, sorry?
20 56 Q. In terms whenever you complained about the allergic 12:14
21 reaction that Alicia was having. So, you have
22 described how you complained to Muckamore and you were
23 asking for her to be taken off the medication, and
24 H338, you spoke to him about it and you felt that he
25 wasn't taking you seriously? 12:14
26 A. He was totally dismissive, you know. He thought he
27 knew everything and who was I, I was only Ms. Bloggs, I
28 would have no intelligence. That's the way I felt. I
29 felt that he was exerting his power and that he knew

1 best. And honestly, I was pleading with him, you know,
2 and I was in a sense threatening that I was going to
3 report him. Nothing worked. He, as far as he was
4 concerned, he was right and he was not listening to
5 anything I said. 12:15
6 57 Q. Did you ever make that formal written complaint about
7 that incident?
8 A. In truth I can't recall.
9 58 Q. You've provided some --
10 A. I think I rang, sorry, Musgrave and verbally spoke on 12:15
11 the phone and raised that.
12 59 Q. Musgrave being the Complaints Department --
13 A. The Complaints Department, yes.
14 60 Q. -- of the Belfast Trust. You have provided some
15 documents which are exhibited to your statement in 12:15
16 relation to complaints. Can you ask you to look at
17 page 41? If you look at the top of the pages, there
18 are numbers on them. If we could bring up page 41 on
19 the screen as well, please.
20 A. Yeah. 12:16
21 61 Q. Have you got that? You can see there's a letter there
22 from the Belfast Trust dated June 2016, and there's a
23 reference there to you having met with H40 and H50 in
24 relation to ongoing concerns about the outcome of your
25 complaint? 12:16
26 A. Yes.
27 62 Q. Does that relate to this incident?
28 A. It does.
29 63 Q. It does. You can see there on the second paragraph, it

1 says:
2
3 "I trust that you are assured that there is appropriate
4 supervision of junior doctors and that Dr. H40 did
5 discuss your complaint with the junior doctor involved 12:16
6 and that the doctor has reflected on and learnt from
7 this experience. Dr. H50 and Dr. H40 have also advised
8 that your experience will be shared at the doctors
9 monthly teaching session. At the meeting it was agreed
10 that there would be an audit to identify and quantify 12:17
11 the need for doctors in Muckamore Abbey to access
12 outside specialists for your patients."
13
14 A. But wouldn't you think they'd have already know that?
15 64 Q. My next question is did that satisfy you? 12:17
16 A. No. But it was a hospital so, you'd think, you know,
17 they would have already had these procedures in place.
18 You didn't expect for me to come along to teach them
19 that that's what they had to do in the aftermath of a
20 severe allergic reaction. They should have known that, 12:17
21 that should have been part of their procedure. So no,
22 I wasn't satisfied.
23 65 Q. Did you ever hear anything more about this? There is
24 reference to there being, for example, an audit to
25 identify and quantify the need for doctors to access 12:17
26 outside specialists. Did you ever --
27 A. It was me actually suggested it.
28 66 Q. Did you ever hear that that had happened or an outcome
29 of that?

1 A. No. I did -- I do recall saying, well, I look forward
2 to being informed about what you are going to put in
3 place to prevent this from happening again, and in my
4 opinion it should be on the computer, and that if
5 anyone is prescribed medication that has a severe 12:18
6 allergic reaction risk, that there should be a red flag
7 flowing that then indicates that the doctor is aware --
8 or sorry, the consultant psychiatrist is aware that
9 there's a risk. Nobody ever came back. I said I look
10 forward to it but it was never ever mentioned again. 12:18
11 67 Q. When you were raising those things at the time, were
12 you told whether those sorts of procedures were in
13 place already?
14 A. No, they says that's a good idea. I think they were
15 trying to pacify me but they said that's a good idea 12:19
16 and, you know, we could take that forward to do that.
17 So, they obviously hadn't it in place or they would
18 have been able to tell me that it was in place.
19 68 Q. Okay. One of the other things that you have described
20 in respect of medication was the general prescription 12:19
21 of antipsychotic medication for Alicia?
22 A. Yeah.
23 69 Q. You said in your statement that you continually tried
24 to explain your concerns about that to Muckamore.
25 Again I'm not asking you to name names, but can you 12:19
26 explain a little bit more about how you tried to raise
27 those concerns?
28 A. At meetings with the consultant psychiatrist. And
29 there was... I don't need to name names. At meetings,

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1 I would have said -- I recall sitting, you know, and
2 saying, look, why do yous keep giving her these
3 antipsychotics? As yous know, they lower the threshold
4 for epilepsy. She never had grand mal seizures before,
5 she never had static epilepsy before; she has a brain 12:20
6 tumour, she has lesions on her brain, she has issues
7 with her kidneys. And, you know, it's giving her grand
8 mal seizures and it's bringing her to death's door. Do
9 you expect me as her mother to sit back and watch while
10 yous kill my daughter? You know, it's not good for 12:20
11 her, yous to need to stop it. Honestly, if I said that
12 once I said it numerous times, I may have said it
13 differently. But I was fighting for Alicia.
14 70 Q. And what response were you getting for that?
15 A. Again, they knew better. I wasn't being listened to. 12:21
16 They never even considered, you know, maybe we do need
17 to take on board what [P109's mother] is saying. They
18 never did.
19 CHAIRPERSON: You just used the surname.
20 MS. KILEY: Yes. 12:21
21 CHAIRPERSON: Just pause for a second.
22 MS. KILEY: Perhaps we'll pause for a second.
23 THE WITNESS: What did I say?
24 MS. KILEY: Your surname was used. We're just
25 referring to you by your first name. Because of that 12:21
26 it is not transmitted outside the room and the
27 transcript will be corrected as well. Don't worry
28 about that, this happens.
29 A. Believe me, I'm not worried about that. I'm in another

1 zone at this time.
2 71 Q. Just on that, you referred to meetings and you have
3 provided some minutes of meetings that you had with
4 staff at Muckamore in your exhibits. For example, if
5 you look at page 100, you will see minutes of a meeting 12:22
6 on 27th October 2016.
7 A. Sorry, say that again.
8 72 Q. Have you got that? You'll see at page 100, minutes of
9 a meeting on 27th October?
10 A. Yes. 12:22
11 73 Q. You've got that, okay. We can see in this that you
12 said that this was an example, that you raised at
13 meetings your issue with antipsychotics?
14 A. Mmm.
15 74 Q. We can see that at page 100, for example under the 12:22
16 heading "Concerns" there, you can see what you say
17 about the allergic reaction that Alicia had and various
18 other drugs. Just halfway down page 101, we can see
19 it's recorded:
20 12:22
21 "Alicia's mother feels that antipsychotic medication
22 has had an adverse effect on Alicia and it has taken
23 time to get back on her feet after the fits and that it
24 left Alicia looking like someone who has had a stroke."
25 12:23
26 It is recorded that you advised in July/August this
27 year that when Alicia was not on any antipsychotic
28 medication, she was in good form and looked well.
29

1 We can see if you turn over the page to page 103,
2 there's a heading halfway down there, "Timeline".
3 A. Mm-hmm.
4 75 Q. We can see one of the responses that is given. It is
5 recorded here: 12:23
6
7 "Dr. H30 agreed that it would be helpful for the team
8 to go through all notes and compile a clear and full
9 timeline of all dosages that Alicia has been on and her
10 reactions to each. Dr. H30 advised that not everything 12:23
11 has been tried. Alicia's mother said that this has
12 been done before by Dr. H40. Dr. H30 advised that ICU
13 is a different ward, and environment and proper
14 timeline of services including positive and negative
15 effects of medication will be an important part of 12:24
16 their assessment. Alicia's mother stated there have
17 been no positive effects of medication."
18
19 A. Right.
20 76 Q. So, that example, we can see there that is reference to 12:24
21 an intention to conduct a timeline of medications and
22 dosages; that in October 2016. Were you aware if that
23 actually happened?
24 A. I don't think it ever did happen. I do slightly recall
25 that conversation with Dr... 12:24
26 77 Q. H30?
27 A. Mm-hmm. No.
28 78 Q. Is your recollection of the meeting?
29 A. Yes.

1 79 Q. But after that meeting, do you ever recall being
2 contacted to be updated about the review that's
3 discussed there?
4 A. No.
5 80 Q. Okay. We then saw from your statement that Alicia was 12:24
6 then started on Haloperidol?
7 A. Yeah. An old antipsychotic drug is how they described
8 it, and she had never tried this before. And I still
9 was resistant in saying, no, I do not want Alicia put
10 back on any antipsychotics. 12:25
11 81 Q. We can see that. If you flick over to page 112, we can
12 see there was a meeting on 18th November 2016?
13 A. Mm-hmm. Yes.
14 82 Q. If you turn over the page to 114.
15 A. Yes. 12:25
16 83 Q. At the final paragraph on that page you'll see
17 discussion about Haloperidol?
18 A. Where, sorry?
19 84 Q. Just in the final paragraph.
20 A. Oh, yes, thanks. 12:25
21 85 Q. We can see there that Haloperidol was discussed at that
22 time, and that there's reference to Alicia being
23 started on a small dose.
24 A. To be clear, Dr. H30 started her on... now, I was able
25 to -- I was being told that because Alicia was talking 12:26
26 to herself that she was a psychotic. And I said but
27 that's from when she was put on antipsychotics at the
28 very, very beginning years ago. She didn't present
29 talking to herself until she was prescribed

1 antipsychotics. I said I didn't think that she was
2 psychotic. I was able to, by the way, take Alicia out
3 into Antrim area to the hairdressers for four or five
4 hours, take her out for lunch and all the rest of it.
5 But she insisted that either I allowed her to treat her 12:27
6 or I could take her home.
7
8 She started her on an eyedrop of Haloperidol, which I
9 think was, again, it gave the power over, the power
10 over, we're the experts and you'll do what I tell you, 12:27
11 and you can't -- you can't object whatsoever. That's
12 the way I felt, and hence she was started on an
13 eyedrop.
14 86 Q. How did she tolerate that?
15 A. Well, I'm sure it didn't affect her one way or the 12:27
16 other and then it slightly increased to 0.5. Which if
17 you were giving a child 5mg on a teaspoon, say, 0.5 is
18 a very, very small amount. So in fairness, she said
19 she would take it slow.
20 12:28
21 But how did she do on that? It ended up in exactly the
22 same place as every other antipsychotic had - led
23 Alicia to grand mal seizures, static epilepsy, nearly
24 dying, and obviously I would say has done damage to her
25 brain. 12:28
26 87 Q. Well, you do say at paragraph 122 of your statement -
27 you don't need it go back there - but you do say there
28 that Alicia continued to be on Haloperidol after her
29 discharge from Muckamore. You refer to her being

1 admitted to --
2 A. 2019.
3 88 Q. 2019, yes. You say that at that time the consultant
4 neurologist told you that 50% of the patients he
5 treated, those seizures were related to antipsychotics, 12:29
6 and it was at that stage she was taken off?
7 A. It's a well-known medical fact that if you suffer from
8 epilepsy and you're given an antipsychotic drug, it
9 lowers your threshold for epilepsy. So, hence why
10 Alicia suffered from epilepsy. She never had a grand 12:29
11 mal seizure, she never had static epilepsy, and yet
12 from the time that she was started on antipsychotics
13 back away - and I can't remember the year off the top
14 of my head - Alicia has been in hospital numerous
15 times, and it has been horrific. 12:29
16 89 Q. And since she has come off the antipsychotics in 2019
17 then, has she had any grand mal seizures?
18 A. She has, which I suspect was due to a medication error
19 which happened in the place she's in now.
20 90 Q. Okay. The next topic that I want to move on to that 12:30
21 you refer to being an issue is what you describe as the
22 mismanagement of transfers. You describe in your
23 statement the various transfers that Alicia went
24 through in Muckamore between different wards and, in
25 particular, there was a move from Cranfield Ward to 12:30
26 Killead Ward which you were concerned about. You said
27 that you felt there should have been a risk assessment
28 for those moves?
29 A. Of course there should.

1 91 Q. Were you aware of any preparations for Alicia for any
2 of her moves through the different wards in Muckamore?
3 A. No, there never was. In particular, the move from
4 Cranfield to Killead, I mean how I was informed was, as
5 I always did - and by the way I was going up to see 12:30
6 Alicia every other day - but I rang to enquire how she
7 was, how her day had been, and I was told they were
8 making the move. That's how I was informed, on the
9 phone.
10 92 Q. You describe in your statement at paragraph 73 lots of 12:31
11 incidents actually after the move and whenever she was
12 in Killead Ward. Whenever those sorts of incidents
13 took place, were you informed about them? So, for
14 example, you described patient-on-patient injuries.
15 A. I would have received phone calls to say there'd been 12:31
16 an incident, and those incidents. So, one of them was
17 that they said that Alicia had, you know, wandered into
18 the pathway of another patient and the other patient
19 doesn't like anyone in their space, so I presume high
20 spectrum autism, the other patient. Alicia wouldn't 12:31
21 have known. And the other patient pushed her and she
22 went flying across the floor and she banged her head,
23 Alicia banged her head.
24
25 Another one was where, apparently, another patient had 12:32
26 grabbed Alicia by the hair, pulled her down to the
27 floor, was on top of her and was punching her and
28 hitting her. There was another patient that Alicia was
29 very fond of, but she had bit Alicia on the back of the

1 hand. Now, Alicia's hand was pure black and blue, you
2 can see the teeth marks. I went up to a meeting in
3 Killead with Laura Waite, and that's when --
4 93 Q. She's your advocate?
5 A. Yeah. And that's when I heard the patient screaming, 12:32
6 which was horrific, God love whoever it was. I've just
7 what-do-you-call-it, had a block in my brain, sorry.
8 94 Q. You were telling us about going up to a meeting at
9 Killead.
10 A. I was telling you about the injury. So, you know, I 12:33
11 recall going up because I had spoke to the staff and
12 said, look, you are going to have to put a 1:1 on the
13 other patient or put a 1:1 on Alicia because I want her
14 protected; I am sick of the amount of abuse and
15 injuries and black and blue marks on my daughter, she 12:33
16 has a right to be protected. Now, I could see the
17 nurses were under a lot of stress because there wasn't
18 enough of them. I genuinely remember speaking to - I
19 can't remember her name - and saying, like, why is
20 there not more nurses? And she said, you know, we're 12:33
21 under -- we're saying the same thing, there should be
22 more nurses.
23
24 So, the point being that in a short space of time and
25 moving to Killead, there had been six or seven 12:33
26 incidents. As I say, I remember giving out about
27 Alicia being bit. I said she needed to be protected,
28 or at least the other patient should be 1:1.
29 95 Q. Did that ever happen? Do you feel that --

1 A. No. They wouldn't have had enough staff and they
2 openly admitted that they didn't have enough staff.
3 And then two days later, even though I insisted that
4 Alicia needed to be protected, she was bit again.
5 That's when I went up to the meeting. I can't remember 12:34
6 the name of the nurse but I recall her saying do you
7 want to take this further? And I says I did, as in I
8 thought they were going to take it forward and go
9 through a safeguarding process, although that's not --
10 I didn't know that process at the time. I thought they 12:34
11 were going to do something and they took it that I
12 wanted to report the other patient to the police. And
13 it was reported to the police, and then when I realised
14 it was reported to the police, I said but I wouldn't
15 take, you know -- the person that bit Alicia, I 12:35
16 wouldn't feel that they were responsible. What I feel
17 is that the hospital was responsible and had a
18 responsibility to protect Alicia.
19 96 Q. And did that safeguarding referral that you --
20 A. It never happened. 12:35
21 97 Q. -- thought would take place happen?
22 A. Nothing.
23 98 Q. Did you ever get an explanation as to why that didn't
24 happen?
25 A. No. 12:35
26 99 Q. You referred to meetings, the meeting that you went to
27 in Killead and we've seen the other meetings you went
28 to. Whenever Alicia was in Muckamore, did you have a
29 named contact person that you could contact if you had

1 concerns?
2 A. What I would now know as a key worker?
3 100 Q. Yes.
4 A. No.
5 101 Q. The other issue that you raised that you had concerns 12:35
6 about was seclusion, so I want to ask you a little bit
7 about that now. You've already heard me read out in
8 your statement what you said Alicia told you about
9 seclusion?
10 A. Mm-hmm. 12:36
11 102 Q. And that she was really scared and was crying and she
12 described it as being --
13 A. Put in jail.
14 103 Q. But you then also describe how you viewed the seclusion
15 room. Can you remember when roughly in time it was 12:36
16 when you viewed that?
17 A. So, it would have been before 6th -- when was that
18 RQIA? When I raised a concern to the RQIA in PICU, the
19 December, was it?
20 104 Q. December, yes. 12:36
21 A. So, it would have been...
22 105 Q. That was 2016?
23 A. Yeah. So, it would have been a couple of weeks, maybe
24 one or two weeks before that that I viewed the
25 seclusion room. 12:36
26 106 Q. One of the things you described was pressing the buzzer
27 and it not working, and you said that you made a
28 complaint to the Belfast Trust about that. I just
29 wanted to turn to one of your exhibits then again at

1 page 47. This is a letter from the Belfast Trust. If
2 page 47 could come up on the screen, please.
3 CHAIRPERSON: You mentioned 16 earlier, not 18?
4 MS. KILEY: No, 2016 was actually, I think, when the
5 witness she said she reviewed this, but we can see the 12:37
6 letter as 2018 and there is reference to a complaint in
7 2017.
8 CHAIRPERSON: Oh, I see.
9 107 Q. MS. KILEY: Can you see that in front of you,
10 Catherine? 12:37
11 A. Yes. So that's referring to the complaints that I made
12 against the RQIA.
13 108 Q. Yes.
14 A. For not doing their job properly.
15 109 Q. Yes. 12:37
16 A. And that they never -- even though I had raised the
17 concerns with the RQIA between 6th and 8th December
18 2016, and that I had asked had they seen the seclusion
19 room, I didn't get a reply. I then said I have seen
20 the seclusion room and somebody needs to do something 12:38
21 about it. I had, what do you call it, said that Alicia
22 had explained that she was frightened, she was scared
23 and they put her in jail. And I said that the
24 seclusion room was not fit for purpose.
25 110 Q. Yes. 12:38
26 A. And somebody needs to do something about it, and what I
27 meant by that was somebody needed to shut it down
28 immediately.
29 111 Q. Was that something that you raised formally? Was that

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1 through a formal complaints process, because we can see
2 you have got a response here in January 2018 from H411.
3 So, was there an earlier complaints process relating to
4 this with the Belfast Trust?
5 A. I could well have done, and I do recognise that 12:39
6 person's name. I could have well have done.
7 112 Q. Okay.
8 A. But to be truthful, I can't -- that person's the
9 safeguarding officer.
10 113 Q. Yes. 12:39
11 A. Yeah.
12 114 Q. Okay. H411.
13 A. So, which -- was she aware of the seclusion room?
14 115 Q. If you look at page 47 there, you'll see H411's title
15 is the Operations Manager? 12:39
16 A. Oh right, yes.
17 116 Q. So, just looking at this letter, you can see that it's
18 a response from the Operations Manager, and it's
19 referring to issues which you raised at the hospital.
20 Halfway down, you can see one of them is, "Seclusion 12:39
21 room."
22
23 Do you see that?
24 A. Yes.
25 117 Q. It says: "This is being looked at and it is hoped that 12:39
26 changes can be made."
27
28 The next line is:
29

1 "Alarm in seclusion room - the ward manager has assured
2 me that this alarm is now checked each time someone was
3 in seclusion, and a staff member remains outside the
4 room as per the seclusion policy."
5 12:40
6 The next section is:
7
8 "Interlock system - it is reported that this is not
9 required in the seclusion room as there is always a
10 member of staff outside the room when the patient is in 12:40
11 it to accompany them into the evacuation point."
12
13 A. I do recall some of the conversation because what is
14 popping into my head is I remember thinking to myself a
15 fire hazard, what happens if there is a fire, health 12:40
16 and safety? So yeah, I can't remember the whole
17 conversation.
18 118 Q. We can see that you raised these issues with the
19 Belfast Trust, and this was the response to them?
20 A. Mmm. 12:40
21 119 Q. I'm just wondering whether, after this letter from
22 H411, you ever heard anything more from the Belfast
23 Trust about the seclusion room or the concerns that
24 you'd raised in respect of it?
25 A. No, and I didn't actually expect that they would ever 12:40
26 do anything because, after all, they'd never listened
27 to Alicia when she was trying to say about the harm
28 that she was enduring. They never listened to me. And
29 I didn't have any trust in them whatsoever that they

1 would actually take on board and do something about it.
2
3 So, I think that was in or around the time, in my mind
4 that I decided, you know, I'm getting nowhere with
5 these people. I decided then I needed to sort of go 12:41
6 outside the inner circle and start raising concerns
7 because, to be honest, I thought - and I think - they
8 were all working in cahoots because I can't comprehend
9 to this day how they didn't take any of what I had said
10 seriously. 12:41
11 120 Q. We can see that you have made various complaints also
12 to the RQIA about those issues, and you provided those
13 exhibits. They run from page 64 onwards to the end of
14 your exhibits. I'm not going to ask you to go through
15 all of those, the Panel has those. 12:42
16
17 The final issue that I wanted to ask you about was just
18 Alicia's discharge because, after that long period, she
19 was discharged on 13th August 2018. You refer to her
20 being on a period of delayed discharge before that. 12:42
21 One of the things you said about that was that you felt
22 that Alicia couldn't see a proper pathway out of
23 Muckamore, and you referred to what you described as
24 the impact of hope.
25 A. Mmm. 12:42
26 121 Q. Can you say a little bit more about how the delayed
27 discharge from Muckamore affected Alicia?
28 A. Profoundly. Because, God love her, she was constantly
29 asking me 'When am I getting home, when am I getting

1 home'? Now, by this stage Alicia had been
2 institutionalised. She had picked up on learned
3 behaviours, you know. I realised that she would need a
4 lot of support in the community. I did ask for that.
5 I was more than willing to take Alicia home. I was 12:43
6 more than -- I never, to be truthful, envisaged Alicia
7 would be living anywhere else, only with me. That two
8 years put a nail in it. That further time destroyed
9 her, unfortunately.
10 122 Q. You were saying you were asking for her to come home to 12:43
11 you. Were you ever told why that wasn't possible?
12 A. Well, they said that there was a younger child in the
13 house and due to Alicia's behaviour. And I said but
14 Alicia's never done any child any harm, so what grounds
15 would they have been basing that on? I don't know why. 12:43
16 I mean, it would have been the perfect answer because
17 Alicia would have been happy, I would have been happy.
18 If they had have put in the proper support and a day
19 centre and things like that, it could have been done.
20 I don't honestly understand why they couldn't have done 12:44
21 it, unless it cost too much money and that's the only
22 thing I can think of, you know. In order to get Alicia
23 out of Muckamore, even though it is not what I wanted,
24 I agreed to -- the only way to get her out was to let
25 her come out and live in the community. 12:44
26 123 Q. Okay. Catherine, those are all the questions that I
27 have for you.
28
29 I know you want the Panel to look at some photos that

1 you provided of Alicia, so I think we can bring those
2 up on the screen now. You provided two photographs.
3 You should see the first one; can you see it in front
4 of you there? Can you describe when that was taken?
5 A. I can't remember, to be honest. 12:45
6 124 Q. Okay.
7 A. I think it might have been when she -- because when
8 Alicia was in Muckamore, I mean she went away on
9 holiday, she came home a lot of the time, at Christmas
10 we went to Fermanagh, you know, for a week; she came 12:45
11 along with us. I can't remember, I'm sorry, when that
12 photograph was taken.
13 125 Q. Well, can we go to the next one because I know this is
14 a photograph that you particularly like of Alicia. So
15 if we can bring the next photo up, please. We can see 12:45
16 her there all dressed up, it looks like. What she's
17 doing that there?
18 A. That was their formal.
19 126 Q. And that's you in the photo with her, is it?
20 A. It is. God bless. Isn't she beautiful? 12:45
21 127 Q. She is, and she looks very like you, I think, in that
22 photo.
23 A. Thanks.
24 128 Q. That's her school formal, is it?
25 A. Yes. 12:46
26 129 Q. So, back whenever she was about 16 or 17, would that
27 be?
28 A. No, I think she might have been 18 or 19.
29 130 Q. Okay. Okay. That's how you would like the Panel to

1 think of Alicia; isn't that right?
2 A. (No response).
3 MS. KILEY: Catherine, I know you want to take a little
4 break to have a think about the evidence you have
5 given. It may be that it is appropriate to take the 12:46
6 lunch break, then.
7 CHAIRPERSON: Of course. I know you want to talk to
8 us, as it were. We have got another witness later but
9 we're not obviously we're not in any rush. Will you be
10 ready in about 45 minutes? Would that be long enough 12:46
11 for you?
12 THE WITNESS: That is fine.
13 CHAIRPERSON: I know lunch is being brought in for you
14 so we can look after you.
15 12:47
16 We will try to sit again at half past one. I know we
17 have quite a bit to do this afternoon. Thank you very
18 much.
19
20 THE INQUIRY ADJOURNED FOR LUNCH AND CONTINUED AS 12:47
21 FOLLOWS:
22
23 P109'S MOTHER WAS QUESTIONED BY THE INQUIRY PANEL AS
24 FOLLOWS:
25 13:38
26 131 Q. CHAIRPERSON: Is this right, that it would be easier
27 for you if we asked you our questions first?
28 A. Yes, please.
29 CHAIRPERSON: I don't think my colleagues --

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1 PROF. MURPHY: No, I think Denise's questions were very
2 thorough. I don't have any further questions for you.
3 DR. MAXWELL: I have no questions.
4 132 Q. CHAIRPERSON: Just a couple of questions that I want to
5 ask. When you took your daughter home, as you did on 13:39
6 occasions, for sort of three or four days she would
7 come home --
8 A. Mmm.
9 133 Q. -- were you given PRN to administer, if needed?
10 A. Yes. 13:39
11 134 Q. Because I think I've seen that in some of the notes.
12 A. Yeah.
13 135 Q. Do you have ever have to use it?
14 A. I'm sure there might have been the odd occasion but I
15 wouldn't have been -- I'd have tried everything else 13:39
16 before I would have went to that.
17 136 Q. I understand that, I just want to know occasionally you
18 got to a point where you might actually have to use it?
19 A. Yeah. It was a rare occasion.
20 137 Q. I understand. All right. Would that be because she 13:39
21 was getting out of hand or a bit violent, or what?
22 A. Sorry, I'm going to have to think. It would have
23 been -- no, it would have been, to be truthful, maybe
24 her saying something like she wanted to go out and me
25 trying to say, you know, you can't go out. 13:40
26 138 Q. Okay.
27 A. And then I could see the agitation building because,
28 from Alicia's perspective, she just thought I should be
29 able to go out to the shop. And then as a preventative

1 from it escalating.
2 139 Q. You knew that that could come?
3 A. I knew the triggers.
4 140 Q. You spoken about when you did make complaints to the
5 Trust, and we have seen the notes, that you didn't 13:40
6 really feel that you were listened to, or nothing
7 changed as a result of what you were saying?
8 A. No, I didn't think it was being taken serious. It was
9 like --
10 141 Q. Okay. You've obviously got an advocate now and you've 13:41
11 had an advocate, is it Laura?
12 A. Now it's Stephanie, yes.
13 142 Q. Stephanie?
14 A. And very good she is.
15 143 Q. You did have an advocate before as well. Did you find 13:41
16 that the advocate was effective, and how were they
17 used?
18 A. In hindsight, I wonder - although she was a brilliant
19 girl and a lovely girl - but did she understand the
20 process? Was she aware of how it worked? Do you know 13:41
21 what I'm saying? She should have been able to inform
22 me, you know, there is a safeguarding process, there is
23 a complaints process, you know. And she did help me
24 with regard to, you know, advising me to phone the
25 likes of Musgrave Complaints Department. 13:41
26 144 Q. Yeah.
27 A. But nobody ever advised me that the process that should
28 have happened was the safeguarding.
29 145 Q. Can you remember when that advocate came into the

1 picture? Did you have an advocate from the very
2 beginning or not?
3 A. No. And I can't even recall how it came about, if I'm
4 being truthful, but I would say... Alicia was in the
5 seclusion room, I think was it late 2015 or 2016? So 13:42
6 sometime before Alicia went into PICU, Laura --
7 146 Q. She was present?
8 A. Yeah.
9 147 Q. All right. Okay.
10 A. And she was very helpful, to be honest. But again, I 13:42
11 suppose in hindsight, she should have known the
12 process.
13 148 Q. But your feeling was even with an advocate, you weren't
14 actually managing to make the changes you wanted to
15 make? 13:43
16 A. No, but then I wouldn't have expected her to change it.
17 I would have expected the professionals within the
18 hospital.
19 149 Q. Yes, sure. No, I understand that. All right. Okay.
20 What do you want to tell us? 13:43
21 A. So, you know, I hope I have portrayed to you how much
22 Alicia suffered in Muckamore, you know, what she
23 witnessed, traumatic events. I'll give you an example.
24 When she was in Cranfield, the second admission, I
25 recall her telling me that another patient, I presume, 13:43
26 had put -- a big pane of glass had broken and the glass
27 all coming in round her and others, and Alicia saying
28 that, you know, she was crying, she was really
29 frightened.

1
2 I do recall being at a meeting sometime shortly after
3 Alicia had told me that, and I had asked had they any
4 psychology input, obviously Alicia had been
5 traumatised, you know. The doctor, H40, and the nurse 13:44
6 that was at that, they listened but they never done
7 that. The point I'm making is that experience - and it
8 did happen again on another ward, believe it or not -
9 but that experience, the flashbacks that Alicia has
10 now. So, the place where Alicia is now, you know, 13:44
11 there was a window and it was broken and Alicia was
12 going into flashbacks and she was reliving it and
13 saying, oh, somebody needs to do something about that
14 window, that glass could break and come in round me.
15 So, clearly it had a very profound traumatic effect on 13:45
16 her.
17
18 You know, being attacked by other patients; while I
19 understand they're not well and they're not held
20 responsible. Indeed, I often wonder all of those 13:45
21 bruises and all of those marks, was it patients,
22 because I only have the word of the people that were
23 apparently supposed to be looking after her.
24
25 You know, Alicia, how she suffered, she does have 13:45
26 flashbacks and she goes into this state where -- and
27 she'll start mentioning maybe patients' names or maybe
28 staff names and it's --
29 150 Q. Is she getting any psychological support now?

1 A. Now. But then that would have been my thought from the
2 very beginning when the abuse or the allegations of
3 abuse, why wasn't there, you know. And she clearly
4 needs it. There was, I think, psychology input from
5 within the community. 13:46
6
7 I'd like to get across to you how much she suffered
8 because these flashbacks, you know, she still hits out.
9 I think she goes into fight or flight. When this comes
10 over her and she's in a flashback, she sometimes can 13:46
11 think other people are people that were in Muckamore
12 if they even resemble, you know. For example, where
13 she is there's a bus and it's quite small at the back
14 so, Alicia's being put in the back. She doesn't like
15 it. I'm in no doubt in my mind, it's the 13:47
16 claustrophobia -- it's the seclusion room she's
17 recalling. And it is soul-destroying, to be honest
18 with you, to see, as I say, how capable she was. And
19 considering that she went into Muckamore suffering from
20 a traumatic event and then to be retraumatised over and 13:47
21 over and over again, as I say, it's cruel.
22
23 As I say, she's suffering profoundly and, as you know,
24 you know all her medical conditions, but she is an
25 amazing woman, she really is and I love her to bits, 13:48
26 and I am very, very proud of her. She's a fighter.
27 She's a survivor. As I said in my statement, I hope to
28 God she survives this kidney transplant because it is a
29 bit complicated with regard to her other medical needs.

1
2 Bear with me, and please do and I'll try to be as quick
3 as I can.
4 151 Q. Just take your time.
5 A. Okay, thanks. You know, the seclusion room, I've all 13:48
6 these questions, I don't know if I'll ever get any
7 answers. But honestly, I cannot comprehend how
8 consultant psychiatrists, social workers, safeguarding
9 officers, the RQIA, senior nurses, nurses, indeed how
10 any other person could have ever deemed that it was fit 13:49
11 for purpose. It could only conjure up - and I've seen
12 it - fear and punishment. It was cruelty and I'd
13 actually say it was torture. No light coming in, so
14 small, nowhere to urinate, nowhere to go to the toilet,
15 you know. It haunts me. You know, whenever I went in 13:49
16 and the brown leather chair, believe it or not if I see
17 a leather chair like it, it automatically triggers it
18 for me, and I often think but what was it like for
19 Alicia. You know, she must have been terrified and
20 felt as if she'd been totally abandoned. I'm in no 13:49
21 doubt it has had a profound, long-term effect on
22 Alicia. As I say, I can't understand how anybody could
23 have ever deemed it fit for purpose. I really can't.
24 I mean, if it had have been a larger room, therapeutic
25 with light coming in where there was a toilet, music, 13:50
26 you know, somewhere where they get reassured, you know,
27 a deescalation room, I could have accepted. It was
28 nothing like that.
29 152 Q. If it gives you any comfort, we have been told the

1 seclusion room is no longer used.
2 A. Oh I know, and it only happened after I spoke to Nolan
3 Show, that's when it got closed down. Yet I raised the
4 concern, I believe in late 2015 or 2016. I reached out
5 to the RQIA. Honestly, I told that girl that day -- 13:50
6 and I did explain what Alicia had said to me, she was
7 scared, she was frightened, she was crying. And again,
8 why in the name of God did she not do something about
9 it?
10 153 Q. Okay. We have got that. 13:51
11 A. So, I'd like answers as to why it was seen as a good
12 practice. Could a consultant psychiatrist and all
13 these professionals not recognise that by putting any
14 person in there would have long-term effects? Where
15 was that supposed to help them, with the trauma and the 13:51
16 issues that they had?
17
18 I believe there needs to be an independent regulator
19 that's not affiliated to the Department of Health,
20 because nothing will ever convince me that when I 13:51
21 reached out to the RQIA and it was supposed to be an
22 unannounced inspection and it wasn't, they knew they
23 were coming. Then when they went up, they spoke to
24 management, they spoke to consultants, they spoke to
25 senior nurses, they spoke to apparently some patients; 13:52
26 they failed to speak to my daughter; they failed to
27 come back and speak to me. I personally feel they from
28 cosying up to each other. They all work for the
29 Department of Health so from my perspective there's a

1 conflict of interest. They're not independent.
2
3 They failed to listen to me and Alicia over and over
4 and over again. I do not accept, I do not accept that
5 the people that worked within Muckamore did not know 13:52
6 that Muckamore was an unsafe environment. I don't
7 accept that because I, on numerous occasions, raised
8 the concerns myself, was completely ignored, and to me
9 they were protecting themselves. They weren't
10 protecting my daughter or others. That's why I feel 13:53
11 strongly there needs to be an independent regulator
12 that's not affiliated to them because certainly the
13 RQIA are not independent and they have failed my
14 daughter. The professionals, consultants, and social
15 workers, they all failed my daughter, and for my 13:53
16 opinion they're all complicit in what happened at
17 Muckamore and what happened to my daughter.
18
19 The safeguarding process within Muckamore was
20 clearly -- it was a bad practice. The safeguarding 13:53
21 practice within the community is just the same today as
22 it was back then. The safeguarding is not fit for
23 purpose because currently, without getting into detail,
24 I've got grave concerns about unexplained bruising
25 where my daughter currently resides. I reported that 13:54
26 on 6th June. Now we're 21st September and it hasn't
27 gone beyond an APP1. I find that quite alarming with
28 all the information that we now know about Muckamore
29 and unexplained bruising, not once but twice. In my

1 opinion it should be paramount and it should be
2 investigated and processed, and I should be involved in
3 that process, and I should get the outcome, an APP8.
4
5 I'm currently waiting on the outcome and conclusion of 13:55
6 a safeguarding investigation as far back as 2021/2022.
7 So, nothing's changed from Muckamore. And Muckamore
8 will happen again; it may not happen on as big a scale.
9 I would be in no doubt that it's happening here today,
10 and I'm in no doubt it will happen again on a smaller 13:55
11 basis because the safeguarding process is not fit for
12 purpose. I actually don't believe that a lot of people
13 that are employed by the Department of Health
14 understand or know the process themselves, I really
15 don't. 13:55
16
17 Sorry, I'm going on and I'll move on as quick as I can.
18
19 In 2021, in around December, Alicia had the Covid - and
20 it is relevant to Muckamore - and she was on a life 13:56
21 support machine. Thank God she survived. In the
22 aftermath, they would have given her a CT scan to see
23 her kidneys. At a further date, after she was
24 discharged and speaking to a nurse, she informed me
25 that they had given Alicia a CT scan of her kidneys and 13:56
26 she said they had detected an old injury of a fractured
27 vertebrae. I said to the nurse, no, you must be wrong,
28 would you just check that in ECR again, which she did.
29 She said, no, definitely, they detected an old injury

1 of a fractured vertebrae, but I said I'm her mother and
2 I never have been made aware of that. Now, I wonder
3 where that happened? I don't know. I understand that
4 the Panel and the public inquiry might never find that
5 but I would like to know, or at least to try to be 13:57
6 established where she obtained that injury.
7
8 Currently -- within Muckamore they never progressed
9 Alicia's abilities; I think they regressed her. But
10 even currently in the community today, I don't think 13:57
11 that there's enough activities and enough things to
12 stimulate her. I do believe that she possesses the
13 ability to do so, because at the beginning of the Covid
14 and she was home with me for over a month, her younger
15 sister taught her how to use the iPad and she's 13:58
16 retained that and is able to do so.
17
18 I'll never give up on Alicia. I always will feel that,
19 you know, she can learn more, and I do believe that she
20 deserves to be given as much support as she should be 13:58
21 given.
22
23 I do think that's it; I'm sure you're glad. Have I
24 missed anything?
25 CHAIRPERSON: Can I just say this, I know you're part 13:58
26 of AFM and I know that you're one of those who fought
27 very hard for this public inquiry, and many years on
28 here we are. You have now helped us by giving evidence
29 and telling us about Alicia. It's obvious also from

1 your evidence that you have fought, continuously, on
2 behalf of your daughter to try to get her better care,
3 and it certainly sounds to me as if you couldn't
4 possibly have done more than you've done.
5 13:59
6 So, I want to thank you on behalf of the Panel. If you
7 do have further thoughts - and I'm sure you will almost
8 as soon as you walk out the door - you are still to
9 take an active part in this Inquiry. You are a Core
10 Participant, and you can feed questions through your 13:59
11 lawyers for other witnesses and you can put forward
12 your thoughts and we will receive them.
13 THE WITNESS: Thank you very much.
14 CHAIRPERSON: In the meantime, can I thank you very
15 much for coming along and assisting us by giving 13:59
16 evidence.
17 THE WITNESS: Thank you.
18 MS. KILEY: Chair, there is the remaining matter.
19 CHAIRPERSON: Is there any need, in fact, to deal with
20 that orally. We have got it, it's in the statement, 13:59
21 we've read it.
22 MS. KILEY: Well, the Restriction Order has now been
23 made, which you made this morning, so it might be
24 desirable as a matter of completeness to read that in.
25 I have no questions that I intend to explore on it, but 14:00
26 they are sections of the statement that haven't been
27 read.
28 CHAIRPERSON: Yes. Okay. Technically there is a
29 reason to do it because a restriction order is

1 temporary, and if at some stage it gets lifted, then
2 there needs to be a record of that material, I suppose.
3 MS. KILEY: Yes. Without it, there will be gaps in the
4 evidence that are unexplained perhaps.
5 CHAIRPERSON: Okay. 14:00
6 MS. KILEY: We do, I think, need to take a very short
7 break just to allow the IT staff to move over - and our
8 transcript - to move over to a restricted transcript.
9 THE SECRETARY: I think we have an issue with the
10 speaker. 14:00
11 CHAIRPERSON: Should we take five minutes and get back
12 in as soon as we can?
13
14 You know there's that restricted part of your evidence
15 we're going to deal with shortly and then we'll be 14:01
16 done. We'll just take a quick five-minute break.
17 THE WITNESS: Okay, no problem. Dead on.
18
19 THE INQUIRY ADJOURNED TO GO INTO PRIVATE SESSION
20 14:01
21 THE INQUIRY CONTINUED IN PUBLIC SESSION AS FOLLOWS:
22
23 CHAIRPERSON: Thank you very much. Right.
24 MR. McEVOY: Good afternoon, Chair, good afternoon,
25 panel. The next witness is the brother of P57. 14:44
26 CHAIRPERSON: Thank you.
27 MR. McEVOY: For everyone's reference, his statement is
28 157.
29

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1 P57'S BROTHER WAS THEN SWORN
2
3 CHAIRPERSON: Can I just ask you to pause for one
4 second. Welcome to the Inquiry, first of all. Thank
5 you very much for coming along to assist us. Sorry to 14:45
6 ask you to pause. Okay. Yes, Mr. McEvoy.
7 MR. McEVOY: Thank you, Chair.
8
9 P57'S BROTHER WAS DIRECTLY EXAMINED BY MR. McEVOY AS
10 FOLLOWS: 14:46
11
12 154 Q. MR. McEVOY: Good afternoon, P57's brother. Before you
13 is hopefully a statement dated 13th September 2023. Do
14 you recognise that statement as being your statement
15 prepared for the Inquiry? 14:46
16 A. I do, yes.
17 155 Q. Do you want to then adopt that statement as the basis
18 of your evidence to the Inquiry?
19 A. I do, yes.
20 156 Q. I'm going to read it out into the Inquiry's record. At 14:46
21 the conclusion then I have one or two questions, and
22 then the Inquiry itself may have a number of questions
23 for you.
24
25 "I, P57's brother, make the following statement for the 14:46
26 purpose of the Muckamore Abbey Hospital Inquiry."
27
28 You tell us that you are going to exhibit a number of
29 documents in number fashion.

1
2 "My connection with Muckamore is that I am a relative
3 of a former patient of Muckamore. I was also present
4 in Muckamore during 2008 as a support worker employed
5 by Positive Futures. 14:47
6
7 The relevant time period that I can speak about is 1992
8 to 2010. My brother, P57, was born on 7th April 1980.
9 He was in Muckamore for approximately 18 years from in
10 or about 1992, when he was 12 years old, to 2010 when 14:47
11 he was 30 years old. Whilst in Muckamore, P57 spent
12 time in PICU. My parents raised concerns about P57's
13 length of stay in Muckamore, and they were interviewed
14 by the media regarding their concerns. P57 is now
15 living at home with our parents. My mother provided a 14:47
16 statement to the Inquiry dated 5th October 2022
17 outlining her concerns with regards to P57.
18
19 My statement relates to my time spent in Muckamore in
20 2008 as a support worker employed by Positive Futures. 14:48
21 I worked with Positive Futures for about three and a
22 half years, and I am now a trade union official with
23 the Staff and Workers Association, whose members
24 including healthcare workers. I am also a volunteer
25 caseworker for the Social Care Association (formerly 14:48
26 known as Care Home Advice and Support NI), and a
27 volunteer caseworker in assisting those loved ones who
28 have been in or are still in Muckamore. I attach a
29 one-page profile of the organisation at Exhibit 1.

1
2 Prior to my employment with Positive Futures in 2008 I
3 did not know anything about the Health Service. The
4 only awareness I had of Muckamore was due to my brother
5 P57's admission and attending visits with my family. 14:48
6
7 I trained for approximately six months to be a support
8 worker. This training took place at Trinity Methodist
9 Church in Lisburn, delivered in lecture style with
10 managers speaking to trainees. At least half of my 14:49
11 training was conducted in Muckamore in 2008. I feel
12 the training provided to me was wholly inadequate,
13
14 The training provided was perfunctory and did not
15 properly prepare us for the on-the-job training in 14:49
16 Muckamore. It did not equip us with the skills we
17 needed to deal with the reality of caring in the
18 supported living environment for some very vulnerable
19 adults, some of whom were institutionalised and quite
20 unprepared for supported living. Others had ingrained 14:49
21 extremely challenging behaviour and at least one of
22 them had a very serious medical condition. I was
23 largely trained in health and safety and deescalation,
24 as well as being given a brief introduction to human
25 rights. I was also given pen pictures of the patients 14:50
26 who were to discharged and placed in a supported living
27 facility", **which you name in Lisburn.**
28
29 "In relation to aggressive behaviour, we were taught

1 not to use seclusion as that was something deployed in
2 Muckamore. It was contrary to the Positive Futures'
3 ethos, which was that the facility was the resident's
4 home. We had to manage the situation using the
5 deescalation techniques that we had been trained in. 14:50
6 The difficulty was that our training did not prepare us
7 for the type of behaviour we had to manage. Our
8 challenging behaviour training involved the manager
9 impersonating someone with a learning disability,
10 putting a Mars Bar in his mouth pretending it was 14:50
11 faeces, and then running around the corridor. It was
12 bizarre and useless.
13
14 We were never taught restraint techniques and it was
15 explained that this went against the whole ethos of 14:51
16 what we were supposed to be doing. Restraint was
17 regarded as a bad word that should not be mentioned.
18 The approach was all about persuasion and deescalation.
19 I had no idea that I might have residents whose conduct
20 was so challenging that some form of appropriate 14:51
21 restraint technique would be helpful to prevent the
22 resident injuring themselves or staff. We were also
23 not taught about how to appropriately deal with the
24 resident's personal hygiene effectively whilst also
25 preserving their dignity as that was not supposed to be 14:51
26 part of our job.
27
28 I was not provided with any detailed life story, a risk
29 assessment, or a care plan. This would have been

1 helpful and it would also have been useful to have been
2 provided with any policies and procedures to govern the
3 resettlement process, although I am not sure that there
4 were any at that time.
5 14:52
6 At the time I was employed by Positive Futures, they
7 had a contract with the South Eastern Health and Social
8 Care Trust to provide 24/7 supportive care to those in
9 a facility in Lisburn. That facility is a cluster of
10 four houses in which up to ten adults with a learning 14:52
11 disability live with support from Positive Futures
12 staff. All those in the facility are tenants renting
13 their accommodation from Triangle Housing Association.
14 The domiciliary care facilities are provided by
15 Positive Futures that has been commissioned by the 14:52
16 SEHSC, or the Northern Health and Social Care Trust as
17 the case may be. The tenants had all moved from the
18 facility from long hospital placements where they had
19 been living for some time.
20 14:52
21 I believed it was my job to integrate people back into
22 the community. I understood the difference between
23 those with learning disabilities who are in supported
24 living and those who are in a residential care home.
25 So far as I was advised when I was employed, my role 14:53
26 was to assist and support patients being discharged
27 from Muckamore to the facility to live independently.
28 I understood that would involve helping them prepare
29 their meals, do their laundry, get out into the

1 community, perhaps ensure they remembered to take their
2 medication and switched off appliances. I understood
3 my role was generally to support them to live as
4 independently as possible.
5 14:53
6 I would not have expected that my role would involve
7 taking care of personal hygiene. I expected this would
8 be something that the individuals would be able to do
9 for themselves if they were eligible for supported
10 living. I also did not believe it involved being a 14:53
11 cleaner, as opposed to showing and helping them carry
12 out those tasks themselves.
13
14 The other people I trained with came from all walks of
15 life. As far as I know, not many had any prior 14:54
16 experience in healthcare. I understood that we were
17 all being trained to the standard that the SEHSCT
18 required and had set for Positive Futures. We were
19 informed that we would be learning more about the
20 residents on the job in Muckamore. I understood that 14:54
21 the job would involve shadowing the Muckamore staff to
22 see how the patients' care was managed whilst generally
23 getting to know them so that we could assist the
24 transfer to the facility.
25 14:54
26 After roughly three months' training by Positive
27 Futures, we were put straight into Muckamore. We were
28 given a tour of the site before starting. I can recall
29 the seclusion room and PICU during the tour of

1 Muckamore. We were then put straight on to the ward.
2 I only worked on one ward known either as Conicar or
3 Six Mile. It was a big, open plan all-male ward.
4 There were some single rooms for patients but mainly it
5 was dormitory style where five or six shared. 14:55
6
7 There was no proper introduction for us when we got
8 onto the ward in Muckamore, although I think that one
9 of the managers of Positive Futures may have been there
10 on the first day. There were generally three of us 14:55
11 from Positive Futures working on each shift. We were
12 to follow the shift patterns of Muckamore staff. I
13 understood my role was to simply observe and shadow the
14 Muckamore staff.
15 14:55
16 My initial impression of Muckamore was horrible. The
17 first couple of days at Muckamore were at times
18 terrifying. I could sense a general standoffish
19 atmosphere from both staff and patients. The staff did
20 not inform us about the patient personalities or likes 14:56
21 and dislikes. I recall about seven or eight patients
22 on that ward had severe learning disabilities. My
23 first impression that was Muckamore was very much an
24 institution. The staff did not seem to like the
25 Positive Futures staff being there. They looked at us 14:56
26 as if we had not got a clue of what was in front of us,
27 and they were right. There was no camaraderie between
28 the Muckamore staff and those from Positive Futures,
29 just as a sense of mistrust.

1
2 During my time on the ward, I observed almost no
3 interaction between staff and patients. I dreaded
4 going back the second day there. In fact, I dreaded it
5 the whole time I was there. I know that the others 14:56
6 from Positive Futures felt the same. I recall that one
7 girl disappeared because she could not cope. The staff
8 at Muckamore appeared to be observers rather than
9 carers or nurses.
10 14:57
11 Whilst I was aware that my purpose was to get to know
12 the patients who would be transitioning into the
13 community, we were given no proper guidance on what to
14 do to assist this. I recall some of the patients
15 seemed attached to staff members and would just follow 14:57
16 them around. It was difficult to try and sit and
17 communicate with them. No staff member took a patient
18 and tried to introduce them to me. They did not
19 include me in anything with the patients and I didn't
20 build up any relationship with any staff member or 14:57
21 manager. I don't remember any specific names.
22
23 In my opinion, most patients at Muckamore should not
24 have been there. It seemed the patients were just
25 bored out of their minds. There was very little to do 14:57
26 and although there was a TV, it was rarely on and, if
27 it was, it seemed it was on a channel for staff. I
28 recall one patient who liked to watch cowboy movies and
29 I would sit with him sometimes. There was a swing and

1 a seesaw outside but it was rusty and never used. I
2 attempted to play football with some patients, but this
3 lasted no more than ten minutes as the patients got
4 tired. There was a smoking room at the bottom where
5 patients would go for a smoke, and I would sometimes go 14:58
6 there with them.
7
8 I never seen any activities or outings. I recall on
9 occasion one patient may have been taken out on a
10 Sunday and one or two possibly went to day care. I 14:58
11 recall there was a church services on a Sunday and the
12 Catholic service was held at the top of the room and
13 the Protestant service was held at the bottom. I
14 observed next to no stimulation on the ward. I have no
15 idea what any of the patients would wake up and look 14:59
16 forward to in the morning. The ward was dreary and
17 uninviting.
18
19 The most concerning thing I can recall was morning time
20 on the ward. It was like a scene from Annie. There 14:59
21 would be several patients' personal care being dealt
22 with altogether. Seven or eight patients would all be
23 brought to the bathrooms at the same time. Typically
24 there would be only three or four Muckamore staff.
25 Some of these patients, at least two or three, could do 14:59
26 some of their personal care themselves but the rest
27 could not. There would be one at the sink having their
28 teeth brushed, one in the shower and one getting dried.
29 The rest would be unattended. At least four patients

1 would have been naked at the same time, others might
2 have had a towel. There was a loss of dignity, or no
3 attempt to preserve their dignity.
4
5 There was also an open plan bedroom and patients would 15:00
6 sometimes wander around from the bathroom in a state of
7 undress. The staff were almost robotic and regimental.
8 The whole thing was institutionalised.
9
10 I did not receive any specific trainings in relation to 15:00
11 personal hygiene or, if tasked, how to preserve dignity
12 whilst doing so.
13
14 I did not see assaults or rough handling by staff of
15 patients, but I do not think the staff treated patients 15:00
16 with respect. The patients were largely compliant.
17 Some of these patients had been in Muckamore for very
18 many years. There was one man who had a bedroom by
19 himself. He had nothing in his bedroom but a mattress
20 on the floor. He allegedly threw everything out of his 15:00
21 room. I saw no attempt from staff to find out what
22 might be the reason for this. In general, I was not
23 aware of anyone trying to find out the reason for the
24 patient's behaviour. Some patients seemed to be
25 constantly wandering around the communal areas. 15:01
26 Another would wet himself in the communal area,
27 standing there with his trousers around his ankles.
28
29 My role also involved working nightshifts at Muckamore.

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1 I was provided with a sleeping bag to sleep on the
2 sofas in the communal areas. The patients were in bed
3 from about 9:00 p.m./9:30 p.m. After around
4 approximately 11 p.m. the Muckamore staff seemed to
5 disappear, I am not sure where to. Patients would have 15:01
6 been administered medication to help with sleeping or
7 nighttime anxiety. One man, who was subsequently
8 discharged to supported living in the community, had
9 been administered Diazepam daily for seven years.
10 15:01
11 There was a lot of violence between patients."
12
13 CHAIRPERSON: That should be "several years."
14 MR. McEVOY: Several years.
15 15:02
16 "At times there would have been comments by some of the
17 staff about putting a patient", who you name, "who was
18 a bit of a scrapper in between other patients who were
19 fighting. I understood this to mean that that patient
20 would be called upon to physically intervene (using 15:02
21 violence) to break up a fight. I never observed this
22 practice.
23
24 Nothing had prepared me for the challenging behaviours
25 I would be tasked to deal with. I had seen some of it 15:02
26 when visiting my brother, P57, but I know the others
27 had no experience of it.
28
29 I did not complain about what I had seen at this time.

1 I was not sure how to, although I did talk about the
2 issues to some people and the other Positive Futures
3 staff. I feel I also had difficulty realising what I
4 was seeing as my brother was also in a Muckamore ward
5 at this time. I was very confused about what I was 15:02
6 seeing. When I went to visit my brother P57 over the
7 years at Muckamore with my family, we were never
8 allowed on to the wards.
9
10 At the end of my training in Muckamore, I understood we 15:03
11 would start to gradually transmission the parents over
12 to a facility. I understand a decision was apparently
13 taken that these men were not suitable for the gradual
14 easing-in period. I'm not sure who made this decision.
15 I recall an open day when some of the patients saw the 15:03
16 accommodation at the facility but there were no
17 overnight stays. I remember two of the patients", **who**
18 **you name,** "were brought down in a minibus and moved
19 straight into the facility. I do not know how the
20 other patients got there. I don't know how those 15:03
21 patients could have been prepared for the move to that
22 facility given their vulnerability and understanding.
23 I don't know how they would have had capacity to
24 understand supporting living. Muckamore staff worked
25 in the facility for about a week or two. As far I was 15:03
26 concerned, the Muckamore staff made it clear that they
27 did not really want to be there.
28
29 I did not experience any on-shift training at Positive

1 Futures from any Muckamore staff. I would say that any
2 knowledge I gained during this time was through learned
3 experience.
4
5 I understand that the patients would have care plans, 15:04
6 life stories and medication records prepared for their
7 transition into the community. I was not trained
8 adequately on care records and challenging behaviour,
9 which is what was needed for some of the patients being
10 placed from Muckamore. We were taught to deescalate. 15:04
11
12 Safety and security were also an issue. The residents
13 were unable to get out at night as there was an
14 electric gate that required a fob to open it. During
15 the day, the residents could not have gone out for an 15:04
16 unaccompanied walk. We could not stop them wandering
17 off, but we had to try and encourage them back as soon
18 as possible. Outings had to be properly planned.
19 Despite that, residents did sometimes escape.
20 15:05
21 We were told specifically not to lock the residents in
22 their bedrooms, whatever the circumstances. We did
23 routinely lock the kitchen doors and the dining rooms.
24 Sometimes this was done to try and separate the
25 residents, some of whom had not got on with each other 15:05
26 in Muckamore and that continued in the facility where
27 there would be physical fights. We were also
28 unprepared to have residents who seriously disliked
29 each other to the point where they would engage in

1 physical violence. I subsequently learned that
2 patients who had been living together were very often
3 resettled together on the mistaken assumption that this
4 was appropriate. I query the extent to which any
5 thought was given to the impact of resident mix and 15:05
6 their happiness, wellbeing and the success of a
7 placement.
8
9 When deescalation and distraction did not work and was
10 there no opportunity to give PRN, then leaving the 15:06
11 house, locking the door and staying outside was a last
12 resort. That was never in the training but it did
13 become part of the care plan, which I believe must have
14 been known to SEHSCT, otherwise Positive Futures would
15 never have been included in a care plan. I was unhappy 15:06
16 about essentially locking a resident who was having an
17 outburst in the house. I had been hurt in such
18 episodes.
19
20 Positive Futures staff were authorised to help the 15:06
21 residents with their medication and ensure that it was
22 properly taken. Sometimes we had to put the medication
23 into their food. There was nothing in place in terms
24 of a system or stages to try first before administering
25 PRN. This was left to the staff discretion. Whilst we 15:06
26 got a brief explanation on the use of PRN, I would not
27 have been able to assess if a resident was being
28 overmedicated. I tried not to use PRN, but I could see
29 from the records we were required to keep that some

1 patients were routinely being given Diazepam as PRN. I
2 am not aware that anyone was monitoring trends. I
3 recall PRN being used as a first and very quick remedy
4 to a patient displaying challenging behaviour after
5 only a few minutes. 15:07
6
7 There were three patients from Muckamore in the
8 facility where I worked for about two years. I found
9 this period extremely challenging. In my experience,
10 the patients from Muckamore were not ready for 15:07
11 supported independent living. I doubted that some of
12 them would ever be capable of it. I recall three
13 patients in particular", **and you name them.** "I recall
14 one of those patients being initially transported to
15 the facility and he had to be carried off the minibus 15:08
16 when he arrived from Muckamore. I wondered whether he
17 had been sedated to help with the move. I recall
18 another patient lay on the sofa in the facility for
19 about four days like a frightened cat, trembling. When
20 we got him into his room, it was bare, with nothing but 15:08
21 a mattress on the floor. I understood that that
22 patient would throw out anything of his room and that
23 the bare room was to replicate his Muckamore room. The
24 facility's room was like a prison. I recall trying to
25 introduce items to the room in the facility or the 15:08
26 facility's room and he would throw them back out.
27
28 I recall I brought one of those patients for a walk to
29 Tesco in Lisburn. I thought this is what I was

1 supposed to do to assist in integrating him back into
2 the community. He had never been to a shop before. I
3 got into trouble with Positive Futures in relation to
4 this trip, but this was due to me taking the patient to
5 Tesco as opposed to the management of his behaviour. 15:09
6
7 The patient's placement in the facility ultimately
8 failed. I recall one weekend when that patient's
9 mental health was really bad. I was in the living room
10 with that patient when he was banging his head off the 15:09
11 window, sofa and any surface he could get to. The
12 patient was also trying to headbutt me. I do not know
13 what triggered it. This was a long episode. I had not
14 been trained on how to deal with such an episode in
15 which I could not safely administer PRN. I had been 15:09
16 taught that in extreme situations to contact the
17 on-call Positive Futures manager or a senior support
18 worker, but I would have to manage the situation before
19 anyone arrived.
20 15:09
21 I do not recall the name, but a doctor arrived who
22 decided to section the patient and I believe that he
23 was readmitted to Muckamore. I have no idea why the
24 decision was made for that patient to have been placed
25 in the facility. It was obvious to me that this was 15:10
26 not at all suitable. That patient needed his meals
27 completely cooked for him as he was incapable of
28 preparing a meal, he would not know a kettle from a
29 pan. That patient needed to be told to cut up his food

1 and to slow down when eating. He needed help with
2 every part of his personal care. He wore a pad, which
3 required to be changed and he needed help with that.
4 He needed help having showers and getting dressed.
5 15:10
6 After about a year I moved to a different house in the
7 facility. The only resident was a young fella called",
8 **who you name,** "who had also come from Muckamore. He
9 was not capable of independent living, he needed 24/7
10 care and everything done for him, i.e. his medication, 15:10
11 food and personal hygiene care. It became obvious from
12 that patient's behaviour and response in certain
13 situations that restraint and MAPA techniques had been
14 used on him a lot in Muckamore. My unqualified opinion
15 is that that patient's behaviour suggested that these 15:11
16 techniques had been used on him in Muckamore because he
17 was constantly trying to use his head to hit out, even
18 if his hands or feet were free. I remember being
19 headbutted because of this.
20 15:11
21 I recall lots of incidents with that patient and his
22 aggressive behaviour with staff. I remember an
23 incident with one female member of staff who was due to
24 go on leave to get married. On this occasion, the
25 patient pulled chunks of her hair out. I understood 15:11
26 that patient's care plan was that he had to be locked
27 in the house when displaying violent behaviour. I felt
28 this was so cruel like at a zoo looking in at him from
29 outside, I refused to do it. My refusal to engage in

1 this practice was detailed in dismissal proceedings
2 against me.
3
4 When I was in Muckamore I sat with a man" **who you name**
5 "as he watched the cowboy films. This patient was not 15:12
6 in the house where I worked at the facility but because
7 I felt I had made a connection with him in Muckamore, I
8 would go and speak with him. This patient very quickly
9 became ill following his move to the facility. He was
10 taken from the facility to Lagan Valley Hospital, 15:12
11 Lisburn, and to the Royal Victoria Hospital, Belfast
12 where he received blood transfusions for his illness.
13 I am unsure of the specific illness.
14
15 I was asked to do shifts with that patient in hospital 15:12
16 at this time. The nurses in hospital would not carry
17 out any personal care for him as he was hitting out at
18 them, and I recall being required to do that for him.
19 The patient's health seriously deteriorated. I recall
20 when he was being discharged back to the facility, I 15:13
21 raised concerns about him to nurses in Lagan Valley
22 Hospital as I was so concerned for his wellbeing. I
23 was told by the nurses in Lagan Valley Hospital that
24 they couldn't get involved in that. When the patient
25 was discharged, his room became incredibly hot due to 15:13
26 the underfloor heating not working properly. As a
27 result, the bedroom window had to be opened in
28 November. It took Positive Futures weeks to resolve
29 this.

1
2 It was very distressing to see this patient when he was
3 unwell. I know other staff members also found this
4 very hard. He would be lying on the bed with no
5 clothes on. The patient died in the facility. I know 15:13
6 it was very traumatic for the staff that discovered he
7 had passed away. I had such a good relationship with
8 that patient, and his family requested that Positive
9 Futures staff attend the funeral in Derry and carry his
10 coffin. 15:14
11
12 The patient should never have been discharged from
13 Muckamore. They were just shifting everyone from that
14 ward to the community and I think it was unfortunate
15 that patient just happened to be on that ward. If 15:14
16 there was a threshold for neglect in adult
17 safeguarding, I believe it was certainly met in this
18 case. I am strongly of the view that this patient was
19 not capable of independent living with only supported
20 living staff to care for him. This patient was not 15:14
21 suited to this, and I think he would have been better
22 in a nursing home environment.
23
24 I cannot understand how patients were assessed as
25 suitable for supported living and I made complaints 15:14
26 about it. I felt that I was essentially a care
27 assistant in a residential home. I felt that the
28 effort to make everyone safe meant that I felt as if I
29 was in a mini Muckamore, and that was not what I had

1 signed up for. I wanted to be a support worker helping
2 to integrate long-stay patients from Muckamore and
3 other facilities into the community.
4
5 The manager of Positive Futures", **who you name** "who 15:15
6 subsequently left Positive Futures, encouraged two
7 residents to live together because the manager thought
8 that they had had a sexual relationship in Muckamore.
9 I had to intervene on several occasions to raise
10 concerns about this proposal, which never materialised 15:15
11 in practice.
12
13 I have raised concerns with a number of bodies over the
14 years such as RQIA, SEHSCT, NISCC, the Stormont Health
15 Committee, the Northern Ireland Health Minister, and 15:15
16 the Northern Ireland Health and Safety Executive to
17 raise concerns about the facility and the resettlement
18 process from Muckamore and the implementation of
19 Bamford Review and Equal Lives Report, of whose
20 recommendations I was aware. I attach minutes of a 15:16
21 meeting I attended with the SEHSCT at Exhibit 2 wherein
22 I raised concerns relating to a lack of staff training
23 and patients not being suitable for resettlement to the
24 facility from Muckamore. I felt let down by the system
25 when I raised concerns about the abuse of patients who 15:16
26 lived at Muckamore.
27
28 I am not surprised at the abuse captured on CCTV in
29 2017 in Muckamore. I recall being aware that in

1 September 2014, RQIA was carrying out their yearly
2 inspections at PICU/Cranfield. The RQIA inspection
3 report for September 2014 details that there were 39
4 allegations of abuse on the ward, of which 37 were
5 substantiated. This was when the Belfast Trust started 15:16
6 talking about CCTV. Between November 2015 and February
7 2016 discussions regarding the introduction,
8 implementation and management of CCTV at MAH were held
9 with a range of stakeholders.
10 15:17
11 I am aware that between 2014 and 2016, RQIA held five
12 meetings with BHSCT and Muckamore management in
13 relation to serious concerns raised during their
14 inspections, as is confirmed in a response dated 19th
15 August 2020 from the RQIA to a freedom of information 15:17
16 request on 17th July 2020, a copy of which I attach at
17 Exhibit 3. I do not believe these appear in the
18 minutes of the BHSCT Board meetings for Muckamore, as
19 was confirmed by the Leadership and Governance Review
20 Report 2020. I do wonder how that is possible. I 15:17
21 believe the 2012 Ennis Ward Adult Safeguarding Report,
22 RQIA September 2014 PICU Report, and the RQIA concerns
23 meetings with the BHSCT should have all been red flags
24 that something was not right at Muckamore.
25 15:18
26 I attended the September 2019 BHSCT Board meeting to
27 ask the BHSCT chief executive in person why he had not
28 already resigned because of the failings at Muckamore.
29 At this Board meeting, a non-executive director said

1 that she had a daughter with a learning disability, and
2 she would have no hesitation in having her daughter
3 cared for at Muckamore."
4
5 That's the conclusion of the body of your statement, 15:18
6 P57's brother.
7
8 I have a very small number of questions. Can you just
9 confirm for us in terms of the on-the-job, as you
10 describe it, training that you had in Muckamore, how 15:19
11 long that period was?
12 A. If I could recall, it was approximately three to six
13 months. Definitely no more than six months. It was
14 about two or three shifts per week, some day shifts and
15 a couple of night shifts, but it wasn't a very long 15:19
16 period at all.
17 157 Q. Your statement indicates that you didn't witness any
18 abuse *per se* but you do describe -- well, what is the
19 best word for what you described?
20 A. In looking back now, what I witnessed was 15:19
21 institutionalised neglect. As I say in my statement, I
22 never seen any rough handling or any assaults of
23 patients, but I do factor in that my brother was in
24 another ward, very, very close to the ward that I was
25 working at. But, yeah, it was just a drabby ward where 15:20
26 patients' dignity was the last thought on anyone's
27 mind.
28 158 Q. On a more personal note, did your brother's experience
29 and the family's experience of having a son and a

1 brother who had a learning disability impact upon your
2 decision to work in that field?
3 A. Yes. It was my parents'. I had been working in the
4 British Civil Service at the time and my parents
5 recommended that potentially I should apply for working 15:20
6 in the charity whose goal was the resettlement process
7 of patients from Muckamore into the community. It was
8 mooted at the time that my brother was potentially
9 going to be one of the individuals to move to this
10 supported living service in Lisburn. Thankfully my 15:20
11 parents didn't allow him to go there. But that was the
12 reason my parents had suggested it to me.
13 159 Q. In your statement on page 8 at the bottom of
14 paragraph 33, there's an interesting question that you
15 raise, which is that you query the extent to which any 15:21
16 thought was given to the impact of resident mix - this
17 is in the facility that you describe - on their
18 happiness, wellbeing and the success of the placement.
19
20 Based on your experience, and I suppose your view, 15:21
21 where should that thought process begin?
22 A. Well, it should have began with the patients
23 themselves, the patients' relatives, any advocacy
24 groups that were available, and all of the
25 professionals within Muckamore and other relevant 15:21
26 Health Trusts. It just appeared to me that just
27 because some patients spent many years together on the
28 same ward in a hospital in Antrim, that a decision was
29 taken to move them all as a group; just because they

1 were in the one ward to put them in a group of houses
2 in another part of Northern Ireland. I could never
3 understand how that made any sense, and it still
4 doesn't.
5 160 Q. Following from what you say, was it your impression 15:22
6 that that was one of the very few criteria that were
7 used?
8 A. Yeah. Simply that they were on the same ward together;
9 simply that -- I also factored in that there was a lot
10 of pressure in 2007 and 2008 from the Stormont 15:22
11 Assembly, and I know that the BBC at the time were
12 covering the resettlement process, and potentially 2007
13 and 2008 there was a small period of time where there
14 was a rush to try and get as many patients out of
15 Muckamore as possible, and I did see it as a very quick 15:23
16 haphazard process where square pegs were trying to be
17 put in round holes.
18 161 Q. Thinking back to your training process both in
19 Muckamore and then at the facility, the Positive
20 Futures facility, while it's accepted, I suppose, that 15:23
21 you were a trainee, if I could use that word,
22 nevertheless were you aware of staff in Muckamore and
23 within that facility liaising with their having input
24 from advocacy services on behalf of those patients who
25 were going to be resettled? 15:23
26 A. I only recall one patient having an advocate. I recall
27 that this patient, who I've mentioned, he had an
28 advocate who was based in Scotland, and I don't know
29 how that came about. But there was certainly no

1 presence of Mencap or Bryson House, or anything other
2 advocacy service that our Health Trust uses. On the
3 other side of the resettlement process, we never seen
4 any of those advocacy groups at all.
5 162 Q. Did you ask questions? It's clear from your evidence 15:24
6 that you weren't afraid to at least think about issues
7 and raise them, where necessary. Did you ask questions
8 about that absence or apparent absence of advocacy
9 input locally?
10 A. I didn't, actually. It wouldn't have been something 15:24
11 that I was aware of in 2008 or 2009 that advocacy
12 groups actually existed. As I say, I have never known
13 anything about the Health Service prior to 2008, so
14 that wouldn't have come into my mind at all. But it
15 would have been extremely useful at the time. 15:24
16 163 Q. I suppose, following from that, we're now in early
17 2020s, and based on the experience that you have
18 described both as a family member and also as somebody
19 who has worked in the resettlement process, is there
20 any one or two or otherwise small number of changes you 15:25
21 think, simple changes that could be made to make things
22 better in terms of the resettlement process?
23 A. Well, the key thing, I believe, is relative family
24 involvement, and as much discussion as possible about
25 the person themselves, the patient themselves, where 15:25
26 they're going, what their future may look like. At
27 that time there wasn't, in my experience in working in
28 the resettlement facility. And that's what I sort of
29 call it, a resettle facility in Lisburn. I have been

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1 listening to some of the other witness evidence about
2 resettlement. And that appears to be the theme still,
3 that there's not a lot of family involvement in it. In
4 my view, it can't work without that family involvement.
5 15:26
6 I know one witness said we're the experts, we're their
7 parents, we're their brother or sister. But it will
8 always be wrong, there'll always be problems if that
9 family expert voice is excluded from the process.
10 MR. McEVOY: P57's brother, those are my questions but 15:26
11 it may be that the Panel have some questions for you.
12 CHAIRPERSON: Very. Dr. Maxwell.
13
14 P57'S BROTHER WAS QUESTIONED BY THE INQUIRY PANEL AS
15 FOLLOWS: 15:26
16
17 164 Q. DR. MAXWELL: I have a number of questions that I would
18 like to just ask you about the time you were doing your
19 training placement in Muckamore. So, you said that you
20 were shadowing staff; what sort of grade of staff were 15:26
21 you shadowing?
22 A. There would have been healthcare assistants present and
23 nursing staff. That was it.
24 165 Q. Were you assigned one particular person to shadow?
25 A. No. If you've been in the wards in Muckamore, they are 15:27
26 open plan and there's two or three big sofas. You sort
27 of sat where there was a space on the sofa and you
28 tried to engage in a conversation with some of the
29 staff. But you weren't introduced to who they were,

1 what their role was, what their experience was, what
2 they could possibly tell you that would be beneficial
3 to you. So, staff member A, staff member B, staff
4 member C, I potentially could have guessed by the
5 uniform they were wearing, but it was never as 15:27
6 organised as that.
7 166 Q. It was never clear to you what the role and grade of
8 each of the members of staff was?
9 A. No. As I say, any of the care planning or
10 interventions that took place in Muckamore must have 15:27
11 took place in the manager's office because none of it
12 ever took place out in the ward where we were
13 essentially sitting.
14 167 Q. Did you ever see the care plans?
15 A. No. 15:28
16 168 Q. They weren't live documents that were being used during
17 the day to look at patient care?
18 A. The only time I was in the office where there was
19 potentially paperwork where Muckamore care plans would
20 existed was to go and get cigarettes for the patients 15:28
21 because the cigarettes were kept in the manager's
22 office. That is the only time I was ever in the office
23 where all of the care plans appeared to have been.
24 169 Q. The care plans were in the manager's office?
25 A. Yes. 15:28
26 170 Q. To what extent were the registered nurses actually out
27 on the ward watching what was happening, or were they
28 in the office doing the care plans?
29 A. A bit of both. But when there was staff in the

1 communal area or the ward area, it was just sitting
2 about. 'Patient A needs to go to the toilet, do you
3 want to come and watch Patient A to go to the toilet.'
4 'I'm about to make Patient B's bed, do you want to come
5 with me.' I remember one nurse being surprised that I 15:29
6 didn't know how to make a bed, because she had asked me
7 to help. That's really what it was.
8 171 Q. You say in paragraph 17 that the first couple of days
9 were at times terrifying?
10 A. Mmm. 15:29
11 172 Q. What was it that was terrifying?
12 A. It was that standoffish atmosphere that you immediately
13 sensed. But also for me, of course, going up to visit
14 my brother, we were only allowed to be outside in the
15 reception area potentially, or out at the front door 15:29
16 and my brother would have been brought to the door and
17 off we went. It was actually potentially that's what
18 made it terrifying for me, knowing that my brother had
19 spent quite a lot of time in this type of environment.
20 15:29
21 Also knowing that I would have to -- my job would be
22 trying to work with very vulnerable patients and
23 resettling them into the community. Within a couple of
24 hours or couple of days, it was automatically knowing
25 that I potentially wouldn't be capable of it, and 15:30
26 nobody else that I had been working in the last three
27 or six months with the bit of training would have been
28 either.
29 173 Q. Why was it that you wouldn't be capable of it?

1 A. Well, it was very quickly apparent that some of the
2 patients on the ward, if not all of them, wouldn't have
3 been capable of what we were being told about supported
4 living, that we essentially stand back, sit on the
5 sofa, assist the vulnerable adult or service user when 15:30
6 they need us. It very quickly became clear that it
7 would be a very hands-on residential care-type
8 environment. Very quickly that became apparent.
9 174 Q. So, presumably the MAH staff were doing that personal
10 care for them? 15:31
11 A. Yeah.
12 175 Q. Did you see the MAH staff doing any other sort of
13 therapeutic interventions?
14 A. No. Every day was hard to get in, every shift was hard
15 to get in. I think some -- two patients in particular 15:31
16 were lucky enough to go down to, excuse me, to go down
17 to another part of the hospital for day care. That was
18 about it. There was nothing. I did essentially feel
19 that, and I think it must have been a resettlement ward
20 that I was on. But it did feel like that, that it was 15:31
21 like a waiting area in an airport. You're waiting and
22 it was just nothing was happening.
23 176 Q. Okay. You then go on to talk in paragraph 22 about the
24 toileting, that they would take groups of patients
25 there and you said there would be seven or eight 15:31
26 patients all at the same time with three or four MAH
27 staff, and then you talk about it being a very
28 undignified process?
29 A. Yes.

1 177 Q. Is that because there weren't enough staff to do it
2 with dignity and care?
3 A. No, that's not the reason why I've described it as
4 such. It was that all the patients were in the
5 bathroom at the same time. 15:32
6 178 Q. Right. So, you feel there would have been enough staff
7 to take them individually?
8 A. I'm not going to say there should have been. There
9 would have been if they'd staggered it a wee bit, of
10 course. But it was like a conveyor belt from one part 15:32
11 of the bathroom to the next.
12 179 Q. That was just the way they did it rather than shortage
13 of staff?
14 A. Yeah, and that was almost terrifying because you didn't
15 know where to stand, you didn't know what to do. You 15:32
16 felt a bit like at a loose end, almost.
17 180 Q. You talked about taking a sleeping bag to sleep on
18 nightshifts, and MAH staff?
19 A. Yes.
20 181 Q. Do you know if the hospital had a policy on whether 15:32
21 staff could or could not sleep on duty at night?
22 A. No. We never seen any policy or procedures in
23 Muckamore. We never seen -- I never seen one bit of
24 paperwork, but all the staff did disappear at night.
25 And the person from the company that I worked for, we 15:33
26 just stayed on the sofas, and you were thrown either a
27 blanket or a sleeping bag and a pillow. I only did two
28 or three nightshifts but that was always the same.
29 182 Q. I'm sorry to keep labouring but these are really

1 interesting points and to hear from somebody who, as a
2 member of staff, has seen it is really helpful for me.
3
4 In the next paragraph, 26, you talk about the violence
5 between patients, and you talk, rather concerningly, 15:33
6 about another patient being asked to intervene. What
7 would staff do if patients were violent with each
8 other?
9 A. I never seen -- that paragraph, paragraph 26 talks
10 about -- that was comments from some of the staff, that 15:33
11 when this patient was much younger that that's what
12 they would have used him for, to break up a couple of
13 scraps.
14 183 Q. So, you didn't see any patients being violent to each
15 other whilst you were on placement? 15:34
16 A. Not to each other, no. No.
17 184 Q. Okay. Then just a point that you've already been asked
18 about resettlement plans and the issue about people
19 being put in the same location because they'd been on
20 the ward together. Both from your family experience 15:34
21 for your brother but also as a support worker, to what
22 extent were family involved in writing the care plan,
23 both before they went to a resettlement facility, and
24 then in the resettlement facility when you were looking
25 after them after they had been moved to that place? 15:34
26 A. That's very easy to answer; none at all.
27 185 Q. None at all?
28 A. Never.
29 186 Q. Even after they had left Muckamore and were living in

1 supported living, the family weren't involved in
2 planning the care?
3 A. Well, I would say never involved -- it never happened.
4 If it did happen, it must have happened in a
5 Southeastern Trust building somewhere outside of the 15:35
6 resettlement facility, like a care review meeting
7 potentially. It was us in the supporting living scheme
8 who were following the care plans. They were in an
9 office in the supported living scheme. If they ever
10 changed, they were only changed by the members of staff 15:35
11 or the managers within the supporting living scheme.
12 Never, ever, ever seen any evidence of any family
13 members being involved in the care management process
14 for supported living. Never.
15 187 Q. Was there a review meeting where you, as a support 15:35
16 worker, were asked to contribute to evaluating that
17 care plan?
18 A. I don't think I went to any care plan meetings with
19 relatives. If they took place annually with the Trust,
20 the Health Trust, it may have been a manager that went 15:35
21 to those.
22 188 Q. And you weren't asked to provide information for the
23 manager to take to any review?
24 A. No. Not at all.
25 DR. MAXWELL: Okay. Thank you very much. 15:36
26
27 CHAIRPERSON: Professor Murphy?
28 189 Q. PROF. MURPHY: I've got a couple of questions for you,
29 please.

1
2 You described three patients who didn't do at all well
3 in the facility you were working in. I think it was a
4 facility for ten people. Did the other people do well;
5 did they manage to stay in the facility? 15:36
6 A. They maybe coped a little bit better than - or adapted
7 is probably the right way to describe it - adapted a
8 bit better than those three that I described. Two of
9 the patients were capable of independent supported
10 living with an intense staffing group always the same, 15:36
11 and a good leadership from management. So, I would
12 probably describe it as three groups.
13 190 Q. Okay. Clearly you were very at sea when you were
14 there. Was there a house manager who gave you guidance
15 about what you should be doing, and whether it was okay 15:37
16 to take a patient to Tesco or not, and all that kind of
17 stuff?
18 A. Yeah, there would have been a senior support worker for
19 each house. For the first two or three years, it was
20 really getting through every day, getting through every 15:37
21 shift. There never seemed to be any plans about
22 community integration, doing things what we all do in
23 the community. The first two or three years when I was
24 there was dealing with incidents of challenging
25 behaviour, dealing with medication errors, dealing with 15:37
26 incidents on nightshift. On some occasions when you
27 did try to take some risks or involvement in the
28 community - I described that one about walking the
29 resident to Tesco, that he had never been in a shop

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1 before - it was no, you shouldn't do that, this isn't
2 that type of supported living environment for that. I
3 thought...
4 191 Q. With more basic tasks like the showering of
5 individuals, for example, did they not give you any 15:38
6 guidance on that either, the senior support workers?
7 A. No. In hindsight, I don't know what -- how that would
8 be. I've never worked in a care home or anything like
9 that. For supported living, I'm not sure how that
10 would looked like. The first experience of having to 15:38
11 do that, personal care, toilet or shower, was when the
12 resident was actually there. You may have had a
13 manager for one or two days, you may have had a couple
14 of Muckamore staff members who were there, but they
15 weren't really interested in being there but they had a 15:38
16 bit of a presence in the houses. It was adapt as you
17 went on. It was do your best as you could.
18 192 Q. From what you said to Dr. Maxwell, you didn't see their
19 care plans when they were in MAH. Did you at least see
20 them once you were in the community setting? 15:39
21 A. Yes. Yes.
22 193 Q. They presumably had been written by staff in MAH, had
23 they?
24 A. Yeah. Well, I would have expected, although I didn't
25 see it, the primary care plan would have travelled from 15:39
26 the Belfast Trust into the supported living service,
27 and we based the supported living care plans on those
28 and then adapted them over time. In fairness, there
29 was a fair attempt to keep those care plans under

1 review and working care plans as much as possible. I
2 couldn't sit here and say that there was no adherence
3 to any care plans in supported living; that wasn't the
4 case.
5 194 Q. Okay. My last question is clearly resettlement, as you 15:40
6 say, at the time was being very rushed, and maybe that
7 explains some of the difficulties. Do you think it's
8 different now?
9 A. I'm not sure about that facility. I would -- I know
10 there was a few rocky periods with RQIA inspections 15:40
11 with the facility for the first three or four years,
12 potentially some of the -- in my statement I talk about
13 one patient having to be readmitted to Muckamore and
14 another patient sadly passing away. Hopefully two of
15 the patients who I thought could have coped very well 15:40
16 with supported living, that they flourished. Some of
17 the other residents who were in that category of
18 potentially over time, maybe they became used to
19 supported living and that was that.
20 15:41
21 In my view, supported living is a fantastic idea. It's
22 a great way to go for people who are appropriate. I
23 don't agree with three or four people living together
24 in the same house simply because they had the
25 unfortunate experience of our government allowing them 15:41
26 to spend years and years and years in the same ward
27 together. But supported living, when it's done right,
28 is an appropriate good thing.
29 195 Q. Absolutely. You tried to give feedback to various

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1 different bodies about what you thought could be done
2 better?
3 A. Mm-hmm.
4 196 Q. Did they take any notice of what you said? Did they
5 change the way -- 15:41
6 A. Yeah, they certainly took notice. They were there
7 physically present in the meetings with me. They
8 listened, they took notes. I didn't know much about
9 the Health Service, I didn't know what it was like to
10 be a whistleblower, I didn't know what it was like to 15:42
11 raise concerns. I now know what of all that brings.
12
13 I didn't know the close relationship with the Trust as
14 being the commissioning Trust, and the organisation I
15 was working for essentially being a private contractor 15:42
16 of those services. I didn't know about that
17 relationship. But, yeah.
18 197 Q. So you felt they were listening?
19 A. Well, they were there present in the room, they were in
20 front of me and they took notes. 15:42
21 198 Q. But presumably, because you left, you had no way of
22 knowing whether they implemented any of the things that
23 you were suggesting to them, did you?
24 A. Yeah. Well, I know they didn't implement them. But
25 the people in the Trust that I was raising concerns to, 15:42
26 they were the people who it was their job, it was their
27 role, to the start of the resettlement process. So I
28 didn't know it at the time but I was essentially
29 raising concerns to the people whose job it was for

1 this not to happen.
2
3 But I tried with the RQIA, I tried with the Northern
4 Ireland Social Care Council; we had some productive
5 meetings there but nothing seemed to change there. I 15:43
6 didn't know anything about RQIA, that they weren't --
7 that they are a regulator within our Health Service. I
8 didn't know anything about that.
9
10 When you raise concerns in the Health Service, people 15:43
11 do listen to you. Whether they take action and get
12 back to you and tell you that you're right or tell you
13 that you're wrong, that's a different matter. I
14 wouldn't have minded if someone told me, no, you're
15 wrong, what you're saying is not right. I wouldn't 15:43
16 have minded that at all because I wasn't experienced or
17 trained in any of this work. But certainly go to
18 meetings and people listen to you, and that's about the
19 height of it.
20 PROF. MURPHY: Okay, thank you. 15:43
21 199 Q. CHAIRPERSON: I just want to begin by getting some idea
22 of timing. Did you start your training in 2008?
23 A. Yes.
24 200 Q. Did you complete sort of three months and then you went
25 off to Muckamore, or... 15:44
26 A. Roughly about that, yeah. The supported living
27 service, it was always delayed, the opening of it was
28 delayed. A bit like the discharge; the discharge was
29 delayed obviously. The opening of the supported living

1 service was delayed, so the organisation I worked for,
2 Positive Futures, they were always trying to come up
3 with ideas what to do with us for a long period of
4 time. I don't know whether the visits and the
5 observations on the wards of Muckamore was always going 15:44
6 to be that that's the idea that they had, because we
7 did also spend time in a day care centre as well for a
8 couple of months.
9 201 Q. So the training that you had, was it general training?
10 A. Yes. 15:44
11 202 Q. Was any of it learning disability-specific?
12 A. It was all learning disabilities.
13 203 Q. It was all learning --
14 A. Yeah.
15 204 Q. Okay. But in that three months, you say you were never 15:45
16 taught restraint techniques. You were taught about
17 deescalation?
18 A. In the supported living environment, yes.
19 205 Q. Yeah.
20 A. I never seen any restraint taking place in Muckamore. 15:45
21 206 Q. No.
22 A. But I knew, obviously, that it did happen.
23 207 Q. Then you went off to Muckamore. I think you mentioned
24 that you saw the seclusion room; is that right?
25 A. Yes. 15:45
26 208 Q. What did it look like when you saw it?
27 A. I can't recall. I've thought about because I know
28 other witnesses, and it's been talked about in the
29 media, that it was a dark dungeon, I can't recall.

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1 Because I knew my brother had spent a significant
2 period of time in Muckamore in seclusion, and he still
3 talks about it. That word, maybe I blanked it out and
4 I didn't want to see it, I'm not sure. I can't recall.
5 209 Q. Okay. There doesn't appear to have been any real 15:46
6 relationship with the staff, and you weren't really --
7 it doesn't sound as if you were getting much guidance
8 from the staff?
9 A. No, we weren't. I didn't hear this from any of the
10 staff but there was rumours around our team, our group 15:46
11 of workers, the staff in Muckamore were worried about
12 losing their jobs, patients being resettled, and you
13 could sense that.
14 210 Q. And that, obviously, was in 2008 when you went there?
15 A. Yeah. Yeah. 15:46
16 211 Q. You did speak about comments from some members of staff
17 about putting a particular patient in between other
18 patients, or to stop fighting?
19 A. Yes.
20 212 Q. Can you remember the circumstances in which you 15:46
21 overheard that conversation?
22 A. They were just casual conversations on the sofa, trying
23 to fill time, and potentially staff coming off with
24 phrases or stories in the past. They weren't bravado
25 phrases or anything like that ,but that's one statement 15:47
26 that stood out for me, that patient in particular was
27 bit of a scrapper 'and we used to put him in amongst
28 patients.'
29 213 Q. Everybody knew that you were not a member of the MAH

1 team, as it were, so they knew that you were a visitor?
2 A. Yes.
3 214 Q. But they seemed comfortable enough to talk about it in
4 your presence?
5 A. Yeah, and that surprised me at the time. It doesn't 15:47
6 surprise me now, given why we're all here, or if you
7 look at the Ennis Report because it was the same sort
8 of circumstances. They're an outside organisation. It
9 surprised me at the time but not now.
10 215 Q. PROF. MURPHY: Do you think it was bravado? Because 15:47
11 you do see bravado sometimes amongst staff in those
12 settings?
13 A. I don't think it was bravado because it was that
14 standoffish atmosphere that existed. We were the last
15 people, group of workers, that they would have been 15:48
16 trying to impress. I got the impression that they sort
17 of thought, well, you don't know what you're in for.
18 So, I didn't think those comments were bravado by any
19 means. I think they were just off-the-cuff, reckless
20 comments. 15:48
21 216 Q. CHAIRPERSON: And you've used the phrase
22 "whistleblower"?
23 A. Mmm.
24 217 Q. So you obviously don't mind talking about it.
25 Obviously, your name's been restricted. But you say in 15:48
26 your paragraph 49 that you raised concerns with a
27 number of bodies over the years. How long did you work
28 for Positive Futures and how long were you at the place
29 we're calling "the facility"?

1 A. Approximately three years, three and a half years.
2 Three/three and a half years.
3 218 Q. Right. When you left the facility, did that end your
4 time with Positive Futures?
5 A. Yes. 15:49
6 219 Q. Right. When you raised concerns with a number of
7 bodies, as you said the RQIA and others, was that as a
8 whistleblower?
9 A. Yes, and I told them so and I followed the company's
10 whistleblowing policy. Yeah, I was... Yeah. There was 15:49
11 quite a lot of buzz at that time about whistleblowing.
12 It was the time of the Baby P case and whistleblowing
13 and patients first, and all of that type.
14 220 Q. Do you remember when this was?
15 A. 2009/2010/2011. My whistleblowing started very, very 15:49
16 quick from working there.
17 221 Q. So, you were taken seriously in the sense that you got
18 access to all of these --
19 A. Yes.
20 222 Q. -- people, including the Health Minister and the Health 15:50
21 Secretary and all that sort of thing?
22 A. Yes.
23 223 Q. What they did with that information was not fed back to
24 you?
25 A. No. Well, when I contacted the RQIA, I did ask for 15:50
26 meetings with them but those never materialised. I did
27 have a meeting with the Northern Ireland Social Care
28 Council about the concerns about the resettlement
29 process, but very little came out of those meetings.

1 224 Q. DR. MAXWELL: You did say earlier in answer that you
2 followed the company's whistleblowing policy?
3 A. Yes.
4 225 Q. DR. MAXWELL: Is that Positive Futures's whistleblowing
5 policy? 15:50
6 A. Yes.
7 226 Q. DR. MAXWELL: Was it because you wasn't satisfied with
8 that response that you then went to other bodies?
9 A. Yes.
10 227 Q. CHAIRPERSON: And you then made a so-called protected 15:51
11 disclosure? That's what you did?
12 A. It wasn't protected. It didn't end up being protected,
13 no.
14 228 Q. DR. MAXWELL: But when you contacted your own employer,
15 Positive Futures, you said 'I'm doing this under our 15:51
16 whistleblowing policy'?
17 A. Yes.
18 229 Q. So they knew you were just offering a very vague
19 comment, they knew you were doing it under that policy?
20 A. Yes. Yeah. 15:51
21 230 Q. And when you went to the RQIA and Social Care Council,
22 did you tell them that it was whistleblowing?
23 A. Yes. The meeting with the RQIA and the Northern
24 Ireland Social Care Council just wasn't me. The
25 meeting with the Northern Ireland Social Care Council, 15:51
26 there was four members of staff there.
27 231 Q. But you were clear it was whistleblowing; it wasn't
28 we'd just like to have a chat?
29 A. No. We were raising serious concerns about neglectful

1 practices, mismanagement, the resettlement process not
2 working, and clearly we were all care assistants in a
3 residential home rather than a supported living
4 service. But, as I've said, they listened but it was
5 almost like this has to work, these supported living 15:52
6 services have to work; we can't just reverse it and
7 send them on back to Muckamore.
8 232 Q. Did you get a written response from any of them,
9 Positive Futures, RQIA, Social Care?
10 A. Well, the response from Positive Futures, my employer, 15:52
11 was the disciplinary process. Some emails from the
12 RQIA sporadically; and the minutes of the meetings with
13 the South Eastern Trust that I attended.
14 CHAIRPERSON: All right. Is there something else?
15 MR. McEVOY: One or two matters arising from that, if 15:52
16 you don't mind, Chair.
17 CHAIRPERSON: Sure.
18
19 P57'S BROTHER WAS FURTHER EXAMINED BY MR. MCEVOY:
20 15:53
21 233 Q. MR. McEVOY: You were asked about the staff talking
22 about incidents, in particular where a patient was set
23 among other patients who were fighting. Were those
24 staff aware that you had a brother who was elsewhere in
25 the hospital? 15:53
26 A. A very good question. I remember asking myself that in
27 the last couple of weeks. I'm not certain. I don't
28 want to give an answer that... I'm not certain. The
29 day centre that I went to, because it was in Lisburn,

1 they certainly knew. I do remember a few times talking
2 about that I was, in my break, going to nip over and
3 see my brother. But I can't be confident that they all
4 knew or even the majority of them knew.
5 234 Q. Okay. Just in relation to, I suppose, the chronology 15:53
6 of your whistleblowing towards the end of your answers
7 to the Panel members. Just to be specific, when did
8 you leave Positive Futures?
9 A. I think late 2011.
10 235 Q. Okay. When did you first have contact then with an 15:54
11 outside body? Let's start with the RQIA.
12 A. Early 2010, mid 2010.
13 236 Q. And the Health and Social Care Council?
14 A. Yeah, all the same. Then for maybe two or three years
15 after as well, after 2011. 15:54
16 237 Q. So we are clear then, you would have begun that process
17 while still an employee of Positive Futures?
18 A. Yes, absolutely.
19 MR. McEVOY: Thank you, that's helpful. Thank you.
20 CHAIRPERSON: Can I thank you very much for coming 15:54
21 forward to assist the Panel. I think you were one of
22 the earlier people who came forward to the Inquiry when
23 we started being advertised, and I'm sorry it's taken
24 such a long time to get to you but for good reasons, as
25 you will understand. Can I thank you very much for 15:54
26 coming to assist the Inquiry today, and that completes
27 your evidence.
28 THE WITNESS: Thanks.
29 CHAIRPERSON: Okay. We are not sitting tomorrow,

1 obviously. I think on Monday we've got the morning
2 free?
3 MR. McEVOY: The note I have is that we're not sitting
4 in the morning and we are sitting at two o'clock.
5 Ms. Briggs will be dealing with the evidence of P128's 15:55
6 father and also then reading in a statement from P123's
7 sister.
8 CHAIRPERSON: Okay. Thank you very much. I wish
9 everybody a good weekend and we'll see you all on
10 Monday at two o'clock. Thank you. 15:55
11
12 THE INQUIRY WAS THEN ADJOURNED UNTIL MONDAY, 25TH
13 SEPTEMBER 2022 AT 2:00 P.M.
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