MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY 20TH SEPTEMBER 2023 - DAY 58

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

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GWEN MALONE STENOGRAPHY SERVICES

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

CHAIRPERSON: I'm sorry to everybody for the late start. Can I just say it is important that witnesses are here, available to Inquiry counsel, for 30 minutes before they give evidence. That's partly because all of these witnesses are going to find the experience difficult. They need to settle down and not be rushed through the door, as it were. Please can I ask, from now on, you make sure witnesses are here in the Inquiry building, available to the inquiry counsel, for 30 minutes. 10:13 10:13

Yes, Mr. McEvoy. 10:13

MR. McEVOY: Morning, Chair, morning Panel. Chair, before we proceed this morning, there is a preliminary issue. You will this morning hear from the sister of P60, deceased. There is an application for a Restriction Order in relation to parts of the statement that she has provided to the Inquiry. Subject to the Panel, I propose to deal with that application immediately itself, subject to restriction. 10:14

CHAIRPERSON: Yes. All right. As I've done in the past, in order to make the application effective, if I grant it, I will make an Restriction Order in relation to the application itself. That's a Restriction Order under Section 19 of the Act. There should be no reporting of this application until it's, in fact, been 10:14

resolved. Okay.

THE HEARING WENT INTO PRIVATE SESSION

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

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

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

expect, be able to fill the time reasonably well with the rest of the evidence we have tomorrow.

Okay, Mr. McEvoy. Let's have the witness.

MR. McEVOY: Thank you, sir. P60's sister, please. 10:20

CHAIRPERSON: The formal order will be drawn up in due course and then published.

MR. McEVOY: Thank you, sir. (Short pause).

THE WITNESS: Good morning.

CHAIRPERSON: Good morning. 10:21

P60'S SISTER, HAVING BEEN SWORN, WAS QUESTIONED BY MR. McEVOY AS FOLLOWS:

CHAIRPERSON: Can I just thank you very much for coming 10:22 to assist the Inquiry. I'm sorry I haven't had time to come through and meet you. However, I gather you only got to the inquiry centre at about 9:50. Are you settled now --

THE WITNESS: I am. 10:22

CHAIRPERSON: -- and ready to give evidence.

You have got your family liaison officer sitting there next to you. Obviously he can assist but there's to be, as I'm sure you understand, no discussion about 10:22 your evidence with him while you're giving it. I'm going to hand you over to Mr. McEvoy.

THE WITNESS: Thank you.

1 Q. MR. McEVOY: Good morning. As you know, my name is

Mark McEvoy and I am one of the Inquiry's barristers. Up to now you have been known as P60's sister. I think we can see from your statement that you have used your first name, which is Angela, and you are content to be known as Angela? 10:23

A. Yes.

2 Q. Accompanying you today is your brother, and that's Christopher?

A. Yes.

3 Q. We are going to be talking about your brother Mark, and we're not going to use any surnames. You're happy enough with that? 10:23

A. Yes.

CHAIRPERSON: Can I just say, it's very unlikely to happen in those circumstances, but if a name does get mentioned which shouldn't, please don't fuss about it or panic. We simply stop the feed and it is taken out of the transcript. So, nothing will happen. 10:23

THE WITNESS: I'm happy enough for Mark's surname to be told. 10:23

4 Q. MR. McEVOY: I think to be preserve everybody's dignity, we will just operate on the basis of first names. That is how we've done things. If you're con tent with that, we'll use your first name, Angela. 10:23

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

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

A. Yes.

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

A. Yes.

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

"I, Angela, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry."

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

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

this can be considered a joint statement by the Inquiry.

There are four children in our family. We also have another sibling named Harry. My parents were Mark's next of kin until my mother passed away on 11th January 2014, and my father then subsequently passed away on 28th August 2020. 10:25

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

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

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

10:26

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

Since late 2007, Mark's mental health deteriorated and, due to his symptoms, he required constant supervision to reduce the risk of self-harm. Mark was verbal. He was able to communicate with family, and his brothers took him under their wing. They knew he had a disability so they looked after him and helped him live as much of a normal life as possible. 10:27

Mark lived in the family home with our mother and father before his admission to Muckamore. He enjoyed a quiet life on the farm looking after his animals, cutting grass in the local community, and cutting turf. Mark's pride and joy was his Massey Ferguson tractor. Mark was heavily involved in the community delivery turf. Mark would have been considered a gentle giant in and around the area where we lived. 10:27

Throughout the years living at home, Mark never showed any signs of violence. Christopher and I would subscribe Mark as the most loving, caring, thoughtful brother anyone could be blessed to have. Mark only saw the good in people and he was well thought of in the local community. 10:28

In or about 1990, when Mark was 21 years old, he subjected to a serious sectarian attack and his mental health deteriorated around that time, becoming anxious and depressed. Mark's GP attributed his deterioration to PSTD resulting FROM the sectarian attack. As a 10:28

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

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

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

Mark was admitted by way of a transfer to Cranfield

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

10:30

When Mark was admitted, my family was told he would be assessed and treated. We were advised that Mark's medication would be reviewed and he would be discharged within about 12 weeks.

10:30

In addition to Mark's mental health issues, he also had medical issues that are recorded in a letter dated 27th October 2008 sent from Holywell Hospital to Muckamore, and include severe polydipsia and related periods of hypernatraemia, as well as historically 10:30 aortic stenosis. I was never made aware of this at the time and have learnt this information through medical notes.

As a family, we all visited Mark on a regular basis. 10:31 My father would have visited every day and myself and my mother would have visited four or five times a week. Sometimes Mark would have had numerous visits per day. Muckamore is not very far away from our home and visiting was never an issue. Family visits were so 10:31 important to Mark. I remember him saying that other patients would have passed remark on how frequently we would attend and how much we must have loved him. I attach Exhibit 1, photographs of Mark with family.

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

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

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

be referred to the visitor's room to allow for some privacy, but afterwards Mark would ask that this was not done again as he would be told off and told that he was a bad boy. It was clear he was so afraid of the consequences of reporting what was happening to him. 10:33

During his time at Muckamore, Mark required 2:1 care at all times. I know that there would have been times when he was not cared for by the required member of staff. My family learned that this was due to staffing shortages. 10:33

After approximately 12 to 18 months upon Mark's admission, my family noticed a significant deterioration in his presentation. Both Mark's mental and physical health had deteriorated. My family felt this was not due to Mark's diagnosis but rather it was caused by something else. These issues were raised at Muckamore but no one listened. It was at this point that Mark was detained under the Mental Health (NI) Order 1989. 10:33 10:34

I did not understand what detention meant, I was not advised by any member of staff or social worker. I was provided with no literature regarding detention and what this meant regarding control of Mark's care. 10:34

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

It was clear that Mark was losing a lot of weight and

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

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

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

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

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

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

Mark's detention caused numerous issues. When Mark was

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

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

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

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

telephone to advise of this. We were advised all we were allowed to bring Mark was an apple and a can of drink. This was very hard as Mark looked forward to his treats and we liked bringing them for him. We were not aware of any cameras in Muckamore at this time. 10:39

As time went on, Mark seemed to lose interest in everything. There were few activities in Muckamore for Mark to do, except for playing pool. Mark came from the country and before his admission to Muckamore, he 10:39 would have been outside, active and fully engaged. I did have conversations with the staff on the ward about getting Mark outside on the garden or the farm because he had liked this in the past and it would give him something to do. However, I was told that Mark did 10:39 not want to do this. It appeared to me that Mark was lying in bed all day. Mark's main distraction seemed to be smoking. Mark was a heavy smoker and would have had a cigarette roughly every hour. We would have provided a supply of cigarettes to him and he was 10:40 required 140 cigarettes a week. It was lucky that the family lived nearby and we could all visit regularly to attempt to encourage some activity. We would have taken Mark out of the ward and, when we did, he was very excited to get out. Mark would always be waiting 10:40 for the family to arrive.

Looking back to this period of time, I think Mark was disinterested in activities because of his mental state

being poor from the abuse he suffered in Muckamore.

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

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

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

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

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

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

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

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

7 Q. "It was heartbreaking for my family to see him so neglected and sedated that he could hardly string two words together. 10:44

I remember breaking down. I also remember my father could not contain his emotions and walked out of Muckamore crying. It was the first time I had ever seen my father cry. We noticed bruising on Mark's body

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

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

THE WITNESS: Okay. Continue.

CHAIRPERSON: All right. Thank you.

MR. McEVOY: "We noticed bruising on Mark's body but when we asked, we were told it was due to self-harming. On this occasion Mark was begging us to help him. It 10:45 was heartbreaking to think of the fear Mark felt not being able to see his family for weeks whilst being abused, beaten and threatened with a transfer to England. I believe one of the cruellest things to do to Mark was to threaten to deprive him of contact with 10:45 his family. I believe the idea of being moved to England without the possibility of frequent contact with his mother and father, who were elderly parents who had never been on a plane before, and his siblings, would have been terrible for Mark. 10:46

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

I am aware that Mark was again assaulted a second time by a staff member, and again made a further complaint

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

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

My family had numerous meetings with H40 who kept quoting that Mark had behavioural problems. Dr. H50 just said the same when he took over as consultant. We asked to bring Mark home but were told we had no rights as he was still detained under the Mental Health Act. 10:47

I made numerous calls to the Head of Safeguarding at Belfast Trust but no one would listen and it was always the same outcome. They just said that Mark had severe anxiety and behavioural problems, and the bruising was self-harming. 10:47

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

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

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

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

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

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

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

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

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

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

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

takeaway food for themselves.

My family bought Mark presents, including a TV and DVDs but they disappeared. Throughout the years he was in Muckamore, my family spent hundreds of pounds on items for him to try and make sure that he was as comfortable as possible. This was in addition to the cash that we regularly provided for him. The staff said that Mark smashed up his TV in a rage. Mark said that he did not. Mark did not want us to say anything because he thought he would get into trouble. The same thing happened with four CD players. Each time one went missing, staff advised that Mark had smashed them. My father would say 'So long as Mark is safe, the items can be replaced so say nothing to keep Mark safe'. Electrical items, food, clothes, aftershave, money and cigarettes all disappeared but we said nothing because we knew that Mark would suffer the consequences.

10:53

10:53

10:53

My family also left money on the ward for Mark. Mark had £600 in the main office but when we asked for his money, we were told that he did not have any money and it must be a mistake. Mark always sought to be in control of his money and had a sense of control after it. Each Christmas, aunts would gift him substantial sums and he would never allow us to take it home. We understand that he was allowed £100 on the ward and at least £600 was retained on the ward. Staff became very abusive when my mother asked about this money. When

10:53

10:54

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

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

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

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

his lower back. There is a family history of arthritis and I knew that Mark needed bloods done to change his inflammation markers. Nothing was done, and I made repeated telephone calls until the MRI referral was made. The results showed wear and tear on Mark's back. 10:56
Recommendation were made by physiotherapists that Mark should play basketball but this was not carried out. Another MRI scan was taken and staff said it showed deterioration from the previous MRI. However, the doctor said it showed scoliosis. Our family had no 10:56
help from the ward staff.
At one stage I complained about a mattress being inadequate because it was so uncomfortable that Mark was sitting in a dayroom chair at night. I offered to buy Mark a mattress. A nurse told me it would not be 10:56
approved by health and safety, and another staff member asked who I thought I was for making this offer. One doctor said to me 'Do you think you're a doctor, do you think you know better?'

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

On another occasion when Christopher and I were

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

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

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

I strongly believe that this incident was covered up.

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

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

I would say that any physical issues with Mark were raised almost in reverse. I felt like I was the nurse

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

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

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

Seclusion was a major issue. I understand it was used

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

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

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

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

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

wholly degrading.

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

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

It also states within Mark's note that he would request seclusion and that being locked in would make him feel safe. I questioned why Mark had to be locked in to feel safe and secure within Muckamore ." 11:06 11:06

I'll pick it up at paragraph 71:

"In 2015 Mark was moved to the Six Mile Ward. After this mark was transferred to Cranfield PICU on six

occasions for overnights. I know my family were upset about Mark being placed among forensic patients, but when this was raised, staff were so rude and said it was nothing to do with them. Mark was detained and we were told he would be going to Six Mile because there was an available bed. I understand in July 2015 CCTV was installed on the Six Mile Ward and in the Cranfield wards." 11:06

On the top of page 13 then, paragraph 78: 11:07

"My cousin, contacted Muckamore after H512 was transferred to another ward and asked why he had not been suspended. Eventually we learned that H512 had been suspended. 11:07

I understand from what Mark told me that abuse also occurred in bedrooms and bathrooms. I believe these were not investigated because those areas were not covered by CCTV. 11:07

After we found out about the abuse Mark had suffered, we asked for him to be provided with therapy to help him cope. We were told this was not being provided to him because Mark did not want it. We were convinced that was not correct. 11:07

Another patient would go into Mark's room and use sectarian language and beet him up in his room. This

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

I brought up the use of sectarian language by that other patient with h260, Assistant Ward Manager, and the effect on his PTSD from the attack. She advised she asked someone to have a word. At the time H260 laughed when I raised it and says 'He calls me a Fenian bastard all the time. Don't take it so personally, Angela'. 11:08

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

during this incident.

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

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

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

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

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

2018.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11:19

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

11:20

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

11:20

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

11:20

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

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

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

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

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

Mark had complained of a tight chest for years but this was never investigated a Muckamore.

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

Since the Muckamore investigation, I have suffered terribly during living in the town which is the local area for many Muckamore staff. I recall a very traumatic incident recently when I was visiting Mark's

grave. H54's father was standing at the entrance to the graveyard and waved at me and laughed. The father, H209, was Mark's behavioural nurse while Mark was in Cranfield. I feel like I have not been allowed to grief. This trauma is still ongoing and I have considered moving to another town. I cannot put into words the effect this has had on me. This has made me feel that I was somehow the abuser and not a victim. When I go out, I constantly look over my shoulder and feel intimidated and harassed living in my own hometown. I increasingly feel like a prisoner in my own home, and had to install CCTV and security lights at my own expense, to which the Belfast Trust had approved and then backtracked... 11:24 11:24

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

I want to ensure that another patient will not suffer what Mark suffered for all those years. I feel that no one should have to keep up the kind of vigilance that I will felt was necessary to maintain for Mark to keep a loved one safe. Even then, I could not fully protect him from harm. I also feel that families should not have to resort to legal proceedings to protect the interest of their loved ones, and protect themselves. During Mark's time in Muckamore I felt it was organised 11:24 11:25

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

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

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

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

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

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

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

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

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you very much.

THE WITNESS WAS QUESTIONED BY MR. MCEVOY AS FOLLOWS:

8 Q. MR. McEVOY: Thank you Chair, thank you, Panel. 11:52
Angela, I have just a small number of questions arising from the comprehensive and detailed statement that you have given to the Inquiry. Hopefully, SW2 will be able to assist you with the paragraphs and the pages I'm going to take you to. The first one relates to what 11:53
refers is at paragraph 15 on page 3, please, if you would turn that up.

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

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

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

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

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

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

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

A. Over the years or in late --

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

his death, first of all?

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

12 Q. Okay.

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

13 Q. Okay.

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

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

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

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

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

16 Q. Yeah.

A. But...

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

A. Yeah.

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

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

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

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

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

20 Q. Okay.

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

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

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

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

A. My mum.

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

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

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

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

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

CHAIRPERSON: Thank you.

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

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

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

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

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

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

31 Q. Mm-hmm. In terms of the weight loss and the personal care issues, were those raised with Muckamore staff? 12:04

A. Numerous, numerous times.

32 Q. Okay. Were you given any sort of positive response?

A. No. For example, one comment from a member of staff was 'We can't force him to eat. We can't force him to clean his bum'. That was language that was used from the medical staff. 12:04

33 Q. That's from the medical staff?

A. Yeah.

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

A. Number?

35 Q. It's paragraph 23. So, I'll just read the sentence out for you: 12:05

"From what I have seen, transfers within Muckamore caused Mark further anxiety and on 11th October 2011, following an episode, a further application for assessment was sought." 12:05

Do you see it there?

A. What had happened was, that was Mark being transferred

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

36 Q. Okay.

A. Looking back now, you can see that they seemed to want failure, seemed to want, like, maybe aggression to sedate Mark, you know, to add to his PTSD and his severe anxiety.

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

A. Yeah.

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

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

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

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

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

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

was a detained patient, again it was put back 'this isn't your decision'.

41 Q. If I can take you to 31 on page 5. The very last sentence in 31 is where you tell us a little bit, as you do throughout your statement, about Mark's experience of sedation. The very last sentence says: 12:09

"It seemed to me at this point Mark was constantly sedated rather than managed with the correct combination of medication. It seemed to result in Mark slurring his speech and foaming at the mouth." 12:09

Can you recall how long again into Mark's Muckamore journey he would have begun to be sedated?

A. It was a short period after Mark was admitted, because initially we were told it was for a 12-week assessment, but after a matter of months Mark looked like a stroke patient and that's what he looked like. A young man, stooped over, slurred speech, foaming at the mouth. 12:10

42 Q. The type of medication and its potential side-effects, were those things discussed with you by clinical staff? 12:10

A. No, no. Looking back, he was on antipsychotic drugs. I had asked numerous times for a list of his medication, and the only time that I was given that was when I thought Mark was getting released, was to apply for his PIP. When I looked at the drugs and the amount of medication that he was on, there's no words how he was drugged. He was drugged. And, like, so sedated, he could hardly -- there were times he could hardly 12:10

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

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

A. No.

44 Q. Or with your mum and dad?

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

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

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

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

A. Yeah.

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

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

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

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

A. Yeah.

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

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

50 Q. Yeah.

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

51 Q. Yeah.

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

he's violent. And Daddy said that's not my son, my son is not violent, and they said we can't let you in for your own safety. And that continued for eight weeks. And we rang and rang and rang, no, you can't see him, you can't see him. 12:14

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

A. We got called to this meeting. And we begged, we pleaded, to see Mark.

53 Q. Yes. 12:15

A. And after the meeting they said we'll go and get Mark. Mark walked up the corridor. I'd say he'd probably lost about three stone in weight. He was foaming at the mouth. There was a staff member on each side of him walking him up towards us, and he got on his knees 12:15 and he begged us to help him. He said 'please Daddy, please help me. Please, please help me'. My father - it was first time I'd seen my father cry - and he hugged and hugged Mark, and he turned around and said 'Angela, will you sort this' and he went out of the 12:15 Hospital. The cruelty and the abuse that was inflicted on my brother, it's just -- I'll never forget that day. Obviously we don't have proof, we don't have proof but we know now that Mark was locked up. And Mark said that he was locked up, he was put in seclusion, he 12:16 wasn't fed, he wasn't allowed out to go to the toilet, he wasn't given smoke breaks. You wouldn't treat an animal like that. And this for whatever length of time.

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

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

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

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

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

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

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

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

and I looked at the leaflet.

57 Q. Okay.

A. No one ever told me, nobody ever advised me when I was at this hospital visiting Mark. It was just because of a leaflet that was sitting. 12:18

58 Q. And nobody ever told you -- or were you ever told that there was a HSC complaints process?

A. No. No. I didn't even know even for Mark about the advocate. I wasn't ever told about anything like that. Like, I know this is nothing to do what with what you're asking but -- 12:18

59 Q. No, it is. It's about other people that could have helped, and anything you can tell us about that is very important.

A. Even families, we were kept apart. We weren't even allowed to speak to each other. Like, for example, if you went into the reception area, quickly you were shoved into a visitor's room. So, you know, it's not as if you had support and could speak to another family and say, you know, who are you dealing with, is there anybody that could help you. 12:19 12:19

60 Q. I was just about to ask you about that because you describe that very, very strikingly in your statement, if I might say, and you had the impression that you were kept about. Can you tell us more about that and how you formed that impression? 12:19

A. Well, one example is my father and me had gone up to Cranfield to visit Mark, and we had gone into the reception area and there was another obviously mother

and father sitting. And we went in and I remember as well the receptionist jumped up, and said oh Christy, Angela, I'm going to take you down to the visitor's room. Daddy was a countryman and loved to speak and have a chat, and he said 'Oh no, we're all right sitting here, we'll be okay'. And next minute, she must have pressed a buzzer because there was a member of staff. They were so nice to us when we came to visit, 'Oh Christy, Angela, come on up here, I'll make you a cup of tea', blah-blah. That happened on numerous occasions. We were always kept apart. 12:19 12:20

MR. McEVOY: Okay. Those are my questions at this point. It may be that the Panel have questions for you arising from.

CHAIRPERSON: Dr. Maxwell. 12:20

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

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

A. Yes.

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

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

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

63 Q. Right. And was that full dentures or just partial?

A. Full dentures. 12:21

64 Q. But before he went to Muckamore, he was able to eat properly?

A. Oh, yeah.

65 Q. So, the dentures weren't stopping him eating?

A. We used to keep Mark going that he was the only person we knew who could eat an apple without dentures, so that shows you how his appetite was. He was a great eater; he loved his food. 12:21

66 Q. Okay. That was going to be my second question. Would the fact that the dentures didn't fit properly have stopped him eating? 12:21

A. No.

67 Q. But you are saying he would chew with his gums?

A. He would have chewed with his gums. I used to by him Wine Gums, and he'd said 'You don't need to buy me Wine Gums, I'm not a baby, I can eat toffees'. So no, he was quite able to eat without dentures. 12:21

68 Q. Do you think he got any help with keeping his mouth clean when he was in hospital?

A. Well, I used to leave him up his denture tablets in his wee case and I used to say to him every -- you know, make sure you steep them every night with your tablet to keep them fresh, and rinse them out the next morning. Because he was -- even before he went to 12:22

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

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

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

DR. MAXWELL: Okay. Thank you.

CHAIRPERSON: Thank you. Professor Murphy?

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

A. Before, in the earlier days?

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

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

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

A. Mm-hmm.

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

A. Yeah. 12:23

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

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

Now, this was in later -- in early days, no, but in later years when Mark was in Six Mile, they had said it was offered but Mark had declined. But when I had spoke to Mark, what Mark said was nobody came to see, nobody came to speak to me. And he would have turned around and said 'They're telling you lies again, Angela'. But it wasn't offered in the early days.

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

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

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

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

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

change it, and, you know, put him through hell again, because that's what happened to him over the years. And it was seen by the bruising on the body, the bruising and -- you know, like even looking at Mark's hands, he had them bit and bit. You know, it was like the pressure, the pain. And I used to say to him, you know, about the pain in his back and all, and he just, like, 'It's in here, it's in here' (indicating). As we all know, psychological damage, the pain, the mental torture outweighs physical any day of the week. So I think that's what Mark was trying to tell me in his way. 12:26 12:26

PROF. MURPHY: Okay, thank you.

CHAIRPERSON: I have a few questions. Would you just give me a second. 12:26

THE WITNESS: Okay. (Short pause.)

76 Q. CHAIRPERSON: I just wanted to clear something up. I just want to, first of all, understand something which I suppose was quite basic. Mark was obviously verbal.

A. Yes. 12:27

77 Q. Could speak to you. And had capacity, so most of the time he knew what was going on around him?

A. Yes.

78 Q. You clearly asked about the medication that he was on, and you told us that it was changed often. Were you ever given -- were you ever told 'Well, we can't discuss the drug regime he's on because he has capacity and that's, you know, a private matter'. 12:27

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

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

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

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

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

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

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

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

81 Q. Yes, okay. 12:29

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

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

A. Mm-hmm.

83 Q. You say:

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

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

A. That I know that?

84 Q. Yes.

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

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

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

A. Very. Because see at the start when Mark had said to me about members of staff were bad to him, I didn't believe him. You know why I didn't believe him - and this will never leave me, the guilt that I didn't believe my brother - because I thought no one could be this bad, no one could do this. 12:31

But now I look back, I'm the one that was in the wrong that I didn't believe him, because now I know every word he was telling me was nothing about the truth. 12:31

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

"My family continued to seek a referral for the back pain." 12:31

Then you said:

"At this stage the police became involved." 12:31

A. Yeah.

87 Q. How did that happen?

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

88 Q. Where?

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

89 Q. You're pointing to the bottom, right above the nape of the back? 12:31 12:32

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

Yet again, rang that evening, Mark was complaining terribly with the pain. A few phone calls that night, and then the next morning I had rang, so I had, to ask for an update and asked for the doctor on the ward to see him. And then my brother Chris, he had also rang and there was a doctor at that time - after, I think it was maybe two or three phone calls - there was a doctor seeing him and he had confirmed that Mark was okay. But when I spoke to Mark on the phone, he was saying he was in so much pain. So, when I spoke to the doctor, I 12:32 12:32

said Mark needs referred to A&E, and he was the one who says 'I'm the doctor, why do you think you know better than me'.

90 Q. Right.

A. And that was when my brother Chris rang the police to explain the situation. 12:33

91 Q. I see, okay. So, it was the family who involved the police?

A. Yeah. Within 15 or 20 minutes there was an ambulance up at Muckamore to take Mark to A&E. 12:33

92 Q. Okay. Finally this from me, you'll be glad to know. If you go to paragraph 63, you're talking about seclusion, and you say that he was regularly placed in seclusion or voluntary confinement?

A. Yeah. 12:33

93 Q. "Mark's notes and records contain numerous references. Extracts from a single week are provided with this statement by way of example." We haven't actually got that. Has that been provided to your solicitors or to the Inquiry? Do you know where that is? 12:34

A. That's with my solicitor.

CHAIRPERSON: Right. We are going to ask, please, for that. All right.

That's all that I've got to ask you for the moment. Do we now need to go to restricted session? We're not going to rise. I don't think there's any need to. The Restriction Order that I made earlier will now take effect. So, can I ask anyone who has not signed a 12:34

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

MR. McEVOY: Thank you, Chair.

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

THE HEARING WENT INTO PRIVATE SESSION

THE INQUIRY CONTINUED IN PUBIC SESSION AFTER LUNCH AS FOLLOWS: 13:25

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

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

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

that's what's proposed.
CHAIRPERSON: That is. Obviously we'll leave it to you to summarise those parts you think can properly be summarised, but everybody should understand the Panel will have read all of the statement. 14:12
MR. McEVOY: Yes. Thank you, Chair.
CHAIRPERSON: Thank you.
MR. McEVOY: I'll begin then with P63's sister telling us that she has made the statement for the purpose of the Inquiry; that she will exhibit her documents in the 14:12
normal way; confirming that her connection with Muckamore is that she is a relative of a patient. The relevant time period she can speak about is between 1992 and 2018.

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

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

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

I'm not proposing to read the following paragraphs,

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

CHAIRPERSON: In short, she challenges whether that diagnosis was correct or not. 14:13

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

CHAIRPERSON: Which, again, the Panel is aware of. All right. 14:13

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

14:13

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

14:13

I am three years older than P63. We were very close growing up and as adults up until his death in 2021. When P63 was three-months-old, our father broke his back in a motorcycle accident. He was paralysed and had to stay in hospital for three years. As children, 14:14 due to our mother's medical history and our father's debilitating injury, we were in a foster home and a care home. We also had to spend time with an aunt and uncle until I was old enough to refuse to go into care

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

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

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

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

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

admission in 1992 which is a bit before the Terms of Reference, Chair. Of course, the Panel has evidence about that from the mother and the mother's friend. It is your counsel's view that that doesn't add much to the Inquiry's existing body of knowledge. 14:15

If I take it up at paragraph 11:

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

I visited P63 with my husband over other week. My mother and father visited P63 weekly. P63's view of the world was very black and white. If he liked 14:16
someone, he would cover them with love but if he did not, then he would make his feelings very clear. He was particularly fond of H71, who was a nurse in Muckamore. He called him, H71 and H12, who was a nurse in Muckamore. He also loved H471 who supported him in 14:16
day care as he would bring P63 to football matches.

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

not offer P63 any privacy. My father raised issues with this and insisted on P63 being given a room where he could have some privacy should any issues arise. The common room was also locked. I became aware that P63 was in with sex offenders when I recognised a resident if his picture in the local newspaper. It was not a good environment for P63 and I noticed that his language became increasingly rude. I think it was because they were a group of lads together that encouraged this type of chat. It was difficult seeing him living in an institution; no one wants that for anyone. If it had been any other place that was suitable, he would not have been there. 14:17 14:17

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

My husband and I visited P63 in Muckamore. In the early days of his admission, we would ring Muckamore to let them know that we planned to visit P63. When we arrived, we found P36 to be well dressed. However, over time I began to notice a change in P63's appearance and abilities to do things for himself. It would often take him half an hour to decide what to wear. When I visited him, I noticed he was not as 14:18

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

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

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

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

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

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

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

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

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

about the staff members who I spoke to."

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

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

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

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

MR. McEVOY: Yes.

CHAIRPERSON: All right. Okay.

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

14:24

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14:32
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14:33
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14:33

His state of dress on any given day would depend on

what staff was assigned to him. Mostly was okay but others simply did not care. When P63 felt uncomfortable, this could cause his anxiety and behaviours to heighten. With P63, sometimes the best way was simply to step back. On other occasions when P63 had a particularly bad time, he would need restained and the only way to do was to keep in a hold position like a bear hug from behind. At times P63 would just need someone to tell him to settle down, as he was like a young child. 14:34

If we thought that P63 was being abused in Muckamore, we would have done something about it. We loved P63 dearly, and simply would not have sat back if we thought he was in any danger or being mistreated. This is why this came as a total shock when I heard about BBC News report mentioning him by name. 14:34

My father was an advocate and champion for P63 up until he passed away in 2017. My father's passing was very hard on P63. He cannot understand that our father was no longer with us and when I explained that he was in heaven, P63 asked when he was coming back. After my father's death, I attended meetings and advocated for P63. 14:35

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

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

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

facility, staff from Muckamore stayed with him during the day approximately two weeks, by which time he had settled in well. P63's relocation to that facility was five minutes from my work so I was able to call in to see him easily. 14:37

I often took P63 out for the day. I could not take him to places where there were lots of people but he enjoyed visiting open farms at quiet times. He enjoyed a KFC on his days out as he thought Colonel Saunders looked like our father. At Christmas time we would drive around Antrim looking at the Christmas lights. 14:37

In my opinion, it was the systems in place and the lack of a more homely environment that let my brother down over the years, coupled with the lack of a more suitable placement that could cope with his condition. I am not sure if the PSNI investigation will find any wrongdoing against my brother. I sincerely hope not. However, if so, I am sure the Inquiry will make the right choices moving forward to allow abuse to be brought to a full stop but also to perhaps open some eyes to the lack of facilities, other than Muckamore, for people like P63. They are people too, just a little more special than you or me and deserve a little more special care." 14:37 14:38 14:38

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

statement.
MR. McEVOY: Ms. Tang is going to deal with that.
CHAIRPERSON: Do we need time for anyone to log on? Thank you.
MS. TANG: Good afternoon, Chair, good afternoon, Panel. The next statement relates to P120's father. The statement is dated 31st August 2023. There are no exhibits with the statement. 14:39
CHAIRPERSON: Thank you.
MS. TANG: The internal page reference number for the statement is 1391. 14:39

"I, P120's father, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. 14:39

My connection with Muckamore is that my son, P120, was a patient at Muckamore. The relevant time that I can speak about is between 2010 and 2014.

I am the father of P120. P120 is 29 years old, having been born on" the date of birth is redacted. "P120 has one brother", whose name is redacted, "who is three years older. 14:39

P120 is currently a patient in" a facility in England, the name of which is redacted, "where he has been since 2014. 14:39

P120 was diagnosed with epilepsy after a seizure at

home when he was a young child. I think that he may have been hospitalised for a period, likely at the Royal Belfast Hospital for Sick Children. During this period, P120 was prescribed medication for his epilepsy and for his behaviour more generally. 14:40

Sometime later, P120 was diagnosed with autism and ADHD. P120 attended a mainstream primary school, but due to his behaviour and specific needs it was felt that this was not best suited and so P120 attended" 14:40 another name redacted, "special school in Belfast letters. P120 was happy at that facility. He attended that facility for a number of years but I cannot recall how long exactly.

14:40

P120's behaviour was generally quite good until he went to MAH. P120's behaviour had deteriorated before his admission but it definitely worsened whilst he was in MAH. P120 became aggressive. He would not want to leave shops, would fall to the ground, and refuse to 14:41 leave. P120 would hit out. Social workers from the Belfast Health and Social Care Trust (BHSCT) became involved when P120's mum left. The senior social workers were H494 and H495. P120 was taken into care for periods." 14:41

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

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

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

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

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

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

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

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

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

be sat in a single chair and locked in the seclusion room. P120 cried to get out. The staff would say that P120 was being very bad. P120 was subjected to the seclusion room many times. No staff member at MAH ever explained what the seclusion room was all about. 14:45

I went to the Sunday Life newspaper to raise awareness of this. P120 had already been sent to England by this stage under an extra-contractual referral or ECR as, apparently, there was no suitable placement in Northern Ireland for him. I also spoke about this with Nigel Dodd, who was then an MP. 14:45

P120 was heavily medicated at MAH. At times P120 appeared completely out of it and spaced out. I threw the tablets back at staff on one occasion and I believe that the staff called police on me because of this. 14:45

I saw marks on P120's body, and bruises. When I queried these marks, the staff would tell me that P120 fell, or that he did it to himself. P120's aunt who would not visit but would drop him off at MAH, saw P120 being roughly handled by staff. I reported my concerns to P120's social workers, H494 and H496, but they did not nothing. They would say it was terrible but did not assist in any way. I felt I had no other choice but to go to a solicitor and report the matters to the police. 14:45 14:46

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

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

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

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

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

The witness then indicates his preferences regarding giving evidence to the Inquiry and provides a declaration of truth. 14:48

CHAIRPERSON: Again, can I thank P120's father, who I know is sitting at the back of the room, very much for that statement. Thank you. 14:48

MS. TANG: Thank you, Chair.

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

MS. TANG: Chair, I wonder if we could have a short break just to allow the next witness to join by Zoom? 14:48

CHAIRPERSON: Yes, okay. I think we'll just sit here and just do some reading while we wait because I think the secretary will be back. Every time we rise, it takes about ten minutes to get back in so it's better if we just sit. Is the next witness P124? 14:49

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

SHORT PAUSE IN THE PROCEEDINGS

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

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

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

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

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

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

Picking up then, Tracey says:

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

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

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

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

14:52

P124 is verbal and can communicate well. He can have a conversation. However, due to P124's learning disability, he can misinterpret certain things that would be said to him and may not fully understand everything. This can cause him to feel elevated levels 14:52
of anxiety. For example, P124 is not always able to say when he is in pain or specify where his pain is coming from. P124 will sometimes communicate by a physical demonstration. It is important to learn about how P124 communicates and to be sensitive to that. 14:53

When P124 was one year old, he started having febrile convulsions which then developed into epilepsy. P124's treating consultant at that time advised it would be best to start P124 on Epilim to help with the seizures. 14:53
P124 was prescribed Epilim up until he was 5 years old. By that age, P124 had stopped having seizures and the consultant then felt that P124's seizures were under control.

14:53

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

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

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

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

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

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

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

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

I would have visited P124 a couple of times a week. I would have taken P124 for walks around the grounds of MAH. I would have brought our family dog, Cindy, with me so that P124 could see her. I was not allowed to leave the hospital grounds with P124. 14:57

After a few weeks in MAH, I noticed that P124 had bruising to his neck and I asked him how this happened. P124 was able to role play this with his father. He showed that he was being held down with a foot on his 14:57
neck. He did this consistently. P120's father and I complained to the Ward Manager, H122. MAH staff investigated. No explanation was ever given to us as to how P124 suffered bruising to his neck as a child. We then went to see senior management, H77, and another 14:57
male staff member who was, I believe, higher up than H77. They all said they did not know how it happened. Nothing was done.

This period in MAH did not seem to make any difference 14:57
to P124's behaviours and difficulties. P124 was still the same after six to nine months. He was still displaying elevated levels of anxiety and elevated levels of aggression. P124 was prescribed Risperidone upon his discharge, which was to apparently take the 14:58
edge of off his aggression, along with Tegretol. There was also other medication prescribed which we were told was to stop P124 from having thoughts of a sexual nature. I questioned why they were stopping this as

P124 was displaying traits of a typical 14-year-old teenager. I was advised by MAH that those sexual thoughts were causing aggression and therefore it was necessary to medicate him. I was never made aware of any possible side-effects. 14:58

P124 had also developed a fair of MAH and was completely petrified of the thought of having to go back there. The fear of potentially having to go back to MAH was, in fact, enough for P124 to moderate some of his specific behaviours. 14:58

We managed P124 at home for nearly ten years, save for a period when P124 was 15 years old and admitted to MAH. This was a struggle but we managed with the assistance of respite and day care. 14:59

In 1999, when P125 was 15 years old, he was admitted back into MAH. I believe he went back on to the Conacre ward. P124 was readmitted as our family was finding it increasingly difficult to manage P124 at home, and his placement at his school had broken down again. 14:59

At that time I was told that MAH would be completing more assessments on P124 and would tweak his medication. P124 was in MAH for around another nine months. Again, we were not allowed to see P124's bedroom or living area. As before, we were only 14:59

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

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

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

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

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

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

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

Thereafter, a meeting was held with H77, the hospital

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

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

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

P124 on holiday and being refused because he was a detained patient. However, because this was never actually explained to me, I did not realise that I was not permitted to take P124 out of MAH. I was never informed of Mental Health Review Tribunals, nor was I involved in any Mental Health Review Tribunals. 15:04

Notwithstanding his detention, P124 would routinely have been allowed to come home for Christmas. I would have picked him up on Christmas Eve and then returned the day after Boxing Day. However, I believe that for Christmas 2011, P124 was not allowed to come home. I challenged this with the ward manager. He would not listen even though I told them that P124 had always been allowed to come home for Christmas. I made alternative arrangements and P124 was only allowed home for Christmas Day for dinner and he had to be returned to MAH that evening. 15:05

Following the Bamford Review and recommendations that a specific number of patients must be resettled into the community by a specific timeline, I can recall I was then informed that P124 was no longer detained under the Mental Health legislation. 15:05

Around 2012, P124 came home for a day visit and I noticed his ankle was swollen. MAH staff advised that he had tripped. I asked why he was not taken to A&E. I took him to A&E and discovered that his ankle was 15:05

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

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

CHAIRPERSON: That's paragraph 30?

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

15:06

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

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

In or around 2018 or 2019, P124 had a bruise to his arm which was explained as resulting from an alteration between P124 and a nurse. The PSNI were aware of this and I was interviewed in a police station. The police said that there was nothing on CCTV. I made a complaint to the safeguarding officer within MAH, H283. H283 met me at the administration building in MAH. P124 had role played to us that he was out for a walk outside Erne Ward when P124's staff member, H467, had asked another staff member to stay with P124 while she got a cup of tea. P124 was not familiar with the male staff member and P124 said to him, 'I'm going to kick your car.' The male staff member then said to him 'You're not going to hit my fucking car', and twisted P124's arm behind his back. When H467 returned, P124 hold H467 that the male staff member had hurt him. H467's response was to deny this. This incident occurred roughly 10 to 15 minutes before I arrived to collect P124 to take him out for the day. On arrival, P124 had told me what had happened. Again, H467's response was to say, 'No, P124, that didn't happen'. It was later that day that I then noticed a bruise appearing on P124's arm. The PSNI investigated this and reviewed the CCTV, but this incident occurred outside of the areas covered by CCTV. Therefore, police considered that there was not enough evidence to

take matters further.

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

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

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

difficulty in waking him up after the anaesthesia. P124 had been diagnosed with sleep apnea in 2012. However MAH failed to disclose this prior to the School of Dentistry prior to the surgical extraction and anaesthesia. 15:11

There were issues with the administration of P124's medication. On occasion, staff would hand P124 nine tablets in one go to swallow without water. This is despite the speech and language therapy team 15:11 identifying some years ago that P124 is at risk of choking.

P124's father and I were allowed into P124's room when he was in Erne. At times we found that his bed had 15:11 been made but there was a strong smell of urine. I checked the bed and it was soaking. This had been left for him to get back into that evening. There were also times when we collected P124, he would have human faeces on him. 15:11

One night when I was putting P124 to bed, he tried to kiss me passionately and inappropriately. He told me that H159 does that to him. H159 was a nurse in MAH at this time. I did not report this at the time. I felt 15:12 like I have never been heard and my concerns were always ignored.

There were failures to follow speech and language

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

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

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

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

P124's money was going and how he was spending so much money in such a brief period. I was told P124 was spending his money on taxis to go to bowling or a shopping trip because the MAH bus was hardly ever available to patients. 15:14

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

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

I also believe that P124 had been overmedicated in MAH.

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

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

the patients. In my experience, this room was used to manage P124 and not as a last resort. I have never been provided with the seclusion room policy or had it described to me. I felt that P124 was put into seclusion far too often. 15:17

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

P124 had an incident that led to some discussion with his doctor on 7th August 2022. When the consequences of his behaviour were discussed with P124, he had 15:18 misunderstood and thought he would be sent to the seclusion room in Muckamore. He called this the 'green room.' He became very distressed and anxious. He kept saying that he could not go back there. I asked P124

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

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

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

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

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

MAH have now closed Erne Ward which was the resettlement ward. We have been told that there is now no bed for P124 at MAH, although a return for MAH would be our last resort. We want P124 to be settled in the community. MAH have agreed not to formally discharge P124 as a patient until such time as a proper placement in the community is secured. 15:20

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

I had to issue judicial review proceedings on behalf of

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

15:21

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

CHAIRPERSON: All right. Well again, thank you very much to Tracey, who I think is watching, for that statement. Thank you. 15:21

So, who is dealing with the next?

MS. BRIGGS: I'm dealing with the next statement which is P126's mother. We can call her Edith. I am just going to check with the secretary to the Inquiry that 15:22 everything is in place.

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

CHAIRPERSON: Are you all right to continue or would 15:22 you like a short break?

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

The statement reference is STN-150-1. It is the statement of P126's mother and, as I say, she will be 15:22 called. It is in relation to P126, who has passed away. He passed away in 2017. I'm going to call him by his first name, David.

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

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

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

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

MS. BRIGGS: Edith then writes:

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

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

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

"I separated from David's father and I obtained a divorce. I subsequently met and married David's stepfather. With him, I had a third child". That should say David's half-brother who was born in 1971. 15:24

"David was born at the Jubilee Maternity Hospital, Belfast. I recall that the doctors missed a few things during my labour with David. I do not recall all their names now. My waters broke and I was left in labour for too long. I recall being told this. I recall one of the doctors, she did not listen to me when I was giving birth but she did end up listening to me after that. She ended up being supportive and giving me lifts home. When I was having my other two sons, I felt that the care was much better. I decided not to have more children after having David's half-brother as when I was expecting him, I had over five months' bed rest. 15:24 15:24 15:25

When David was born, he was a happy child but he was sickly. We lived in" and the place is named and redacted. "The valves of his heart did not close at birth and I believe this was because of a lack of oxygen. I noticed David reacted to light but even as a baby I thought there was something wrong with his eyesight. I recognised this when David was small and I 15:25

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

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

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

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

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

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

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

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

15:28

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

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

I separated from David's father and divorced him. We did not have a happy marriage." 15:28

15:28

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

"I recall visiting David when he was admitted to MAH and I remember him at the end of my visit crying when I returned him to MAH staff. David did not really have any speech so he could not really communicate with me in a normal way. I could tell from David's mannerisms what he wanted. I think that obviously a mother knows their child, but an MAH staff member would be able to tell what David needed by watching him and paying attention to him. 15:28 15:29

I recall one incident when David was around six or seven years old that I was told that David had a broken arm. I do not understand how a child of that age gets a broken arm and I was not happy about it. I complained to MAH at the time but I do not think I got a good response. I recall that I was told that David was moving from one ward to another but I do not recall 15:29

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

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

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

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

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

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

that David was receiving so I started showing up unannounced. David had always been well turned out when I visited but when I visited without calling in advance, I found that it would take MAH staff over 20 minutes to bring him to me or let me see him. I believe that this is because they had to get him ready as he was in a poor state of dress and/or cleanliness. 15:30

I recall on one visit, always I am not sure of the date, that David was uncomfortable. When I examined him, the skin of his back was broken. It was red in places, had scabs, and I felt that I could see bone through wounds. I complained to MAH staff and I was told that David did this to himself by taking off his top and scratching his back against door frames. I was not happy with this response. I do not recall who was involved in this incident. I recall asking staff to change his clothing to something more suitable so that this injury could be avoided. 15:31 15:31

I recall another visit, although I am not sure when this was, that David was brought to me and his nose had been bleeding. He had blood on his clothes. I was angry about this and complained to staff and asked that he was tidied up and given fresh clothes. I do not recall who dealt with my complaint. 15:31

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

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

I recall an attempted resettlement of David. I did not like the way that it was handling or how David or I were treated. I am not sure when the resettlement was, but it was to a facility in", and the location is used. "I do not recall the name of the place and I have destroyed most of my papers relating to David. 15:32

I recall that David was sleeping during the day and that he did not settle there. I do not think that David should have been resettled without me being happy about it and agreeing to it. I made sure to stress when resettlement was suggested by MAH that they maintained a place for David there. The resettlement ended and David was brought back to MAH. I do not recall the dates. 15:32

David was returned to MAH. I do not recall the names of the wards that David was on but I did call them every night for updates on his care. I recall David being on a number os wards including Ennis Ward. I recall receiving telephone calls from MAH staff about David and them telling me about incidents or injuries. I do not recall dates or who I spoke to but I ended up being very concerned about the standard of care. I 15:33

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

15:33

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

15:33

CHAIRPERSON: Okay, thank you.

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

15:33

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

15:34

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

15:34

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

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

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

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

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

When David passed away, I told the staff that they

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

15:36

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

15:36

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

15:36

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

15:36

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

15:36

I feel that there should be openness and transparency about what happened at MAH. While my son David is dead and this statement cannot help him, I want to be his voice in this process and make sure that others receive better treatment." 15:37

The statement is then signed over the page at page 8 and dated by the witness, and then the exhibits thereafter follow, the first exhibit being the PSNI records which I have already referenced to you, Chair, 15:37 and photographs, which are redacted.

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

MS. BRIGGS: Yes. 15:37

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

MS. BRIGGS: Thank you, Chair.

15:37

The next statement that is on the running order is the statement of P127. Just give me a moment, I am going to check the position with the secretary. I am informed that P127 won't be attending remotely or in person today but I am ready to read that statement, 15:38 subject to the Panel. I know that after this one, Ms. Tang has one more as well.

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

MS. BRIGGS: I am. This is a short statement, Chair.
CHAIRPERSON: All right. Is the witness zooming in?
MS. BRIGGS: No. The reference STN1-145-1. It is the statement of P127 and it is dated 6th September 2023. It reads as follows: 15:38

"My connection with MAH is that I was a patient at the Hospital. The relevant time period I can speak about is between 2016 and 2017. I cannot recall the exact dates that I was admitted and discharged from MAH. I 15:39
was born on", the date is redacted, "and I am 25 years old. I currently live with my aunt. I have a younger sister who is 21 years old, and she lives with me and my aunt as well.

15:39

I was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) when I was around 14 or 15 years old. I was diagnosed whilst at the Iveagh Centre in Belfast, which is a hospital inpatient facility for young people with a learning disability and mental health problems. 15:39
I was described medication for my ADHD at the Iveagh Centre but I cannot recall the name of the medication. I was describe Diazepam around this time as well. I was in the Iveagh Centre because I was self-harming. When I turned 18 years old, I went to MAH. 15:39

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

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

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

15:41

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

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

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

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

I had visits from my aunt, my dad and sometimes my cousin and his wife. They would bring me treats and sweets. I remember that they were told by staff that they could not take me out of the grounds of MAH but my cousin told them he was an barrister. My cousin complained to staff and they allowed him to take me out. Most of my visits were at the Cosy Corner café in the grounds of MAH. I would go to school and my family would usually visit a couple of times a week after school. 15:43

I was not supposed to have a mobile phone. The staff said I was not allowed a mobile phone in MAH, but my aunt gave it to me so that I could call her and I hid is under my pillow in my room. I had the phone for around four months and when I went to school, I hid it in my bag. 15:43

I cannot remember any of the staff's names on Donegore Ward but they were mainly women. None of the staff were nice to me or the other patients. They would be all nicey-nicey when my family or other people came to visit but when the parents went home, they would were not nice. The staff treated us like rubbish. They did not speak to me in a nice way. I cannot remember anything in particular that they said as it was too long ago and I try not to remember it. 15:43

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

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

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

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

too long ago.

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

15:46

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

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

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

15:46

Over the page, then, the statement is signed and dated.

15:46

CHAIRPERSON: Thanks to Patient 127.

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

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

15:47

The final statement is that of P129's brother. The internal page reference is STN-152-1, and there are no exhibits to the statement. The statement is dated 8th September 2023.

15:47

"I, P129's, brother, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement."

15:48

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

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

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

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

The witness then lists the members of the family. A sister born in 1980; P129 --

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

MS. TANG: Thank you. 15:49

Moving on to paragraph 5, then:

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

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

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

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

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

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

15:51

Due to these incidents taking place a long time ago, I am not able to remember specific dates of incidents or specific names of staff members. I was a teenager when P129 was admitted to MAH but I have included as much detail as I am able to remember during this process. 15:51

P129 was sectioned into MAH on a full-time basis after approximately six months, or perhaps a year, of respite care. I am not sure exactly where, but it was because there were allegations that P129 did something wrong. 15:51 I remember it may have been allegations of fighting with other patients or staff. However, I am not sure. I cannot remember the name of the ward that P129 was on. I only ever visited P129 that same ward for the whole time that he was at MAH. You go into the main 15:51 entrance and take a left to get to the ward. It was in the new part of MAH. I do not know if he was ever on different wards while he was at MAH.

My mother is 129's next of kin and, when we were 15:52 younger, she told us that you could only visit P129 three times a year. I found out a few years later that this was a load of lies. I think she could not cope with seeing P129 in there. My mother and all of the

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

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

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

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

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

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

15:55

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

15:56

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

15:56

15:56

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

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

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

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

15:58

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

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

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

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

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

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

P129 tried to run away several times from MAH. I do not know the actual dates but it was in the first few years of him going to MAH. P129 hated MAH and he tried to take his own life on at least two times that I know about. I do not know the dates as I cannot remember. I was not told by MAH or my mother, I was told by P129. If a staff member told my mother about the suicide attempts, she did not share this information with me. 16:00 16:01

The first time, P129 tried to swallow a spoon. He was found by staff. P129 told me about this when we were out for a walk, and my mother was walking ahead. P129 should have been under watch after that. However, he tried to hang himself with bedsheets another time in his room. He was disturbed by staff during this attempt. P129 told me about this on a visit but I cannot remember the date. I do not understand why someone was not watching him after the first attempt. 16:01 16:01

P129 was sent to a facility in Scotland in 2004. I was very upset about this. I am disgusted that P129 was allowed to be sent to Scotland. The MAH staff said that P129 was trying to kill another patient with a

belt. I do not believe this as P129 is not a danger to anyone. In any case, the patients are not allowed belts in MAH. P129 was sent to Scotland around the time that the allegations of abuse were coming out about MAH, and I think this is why he was sent. P129 has evidence about the abuse of other patients as he told me he witnessed it. 16:02

P129 is in a facility in Scotland. We are trying to get P129 back to Northern Ireland and I am getting help from his social worker, H546. H564 is based in" a facility, "and also SW12, who is the social worker from another facility in Armagh. I do not think that P129 needs to be in hospital; he is not a danger to anyone. I take my children to see him. He is not even on medication anymore in Scotland. He has been in Scotland for 19 years and was in MAH before that from 1995. 16:02

It is not fair that he has been locked up all this time because he was sexually abused as a child and no one helped him. I am determined to get him home and I want P129's voice to be heard. I do not want the staff to get away with how they treated P129 and the other patients at MAH." 16:02 16:03

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

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

All right. Does that conclude the reading for today?

MS. TANG: Yes. My colleague, Ms. Briggs, has kindly let me know that tomorrow we will be hearing from two witnesses. There's a slight change to the schedule. The first is P109's mother at ten o'clock, and then following that P57's brother. 16:03

CHAIRPERSON: Yes. We've shifted the other witness, P110? 16:03

MS. TANG: Yes, that's correct.

CHAIRPERSON: All right. Ten o'clock tomorrow. Thank you very much, everybody, again much. We'll see you all at ten o'clock. 16:04

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

16:04