MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 9TH OCTOBER 2023 - DAY 64

64

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

GWEN MALONE STENOGRAPHY SERVICES

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INDEX

WITNESS PAGE

THE INQUIRY RESUMED ON MONDAY, 9TH OCTOBER 2023 AS FOLLOWS:

P34'S MOTHER SWORN

10:15

CHAIRPERSON: Thank you very much. Are we using ciphers throughout, Ms. Kiley?

MS. KILEY: First names, Chair. So Mary and the patient may be known Matthew.

CHAIRPERSON: I am going to call you Mary, if I may. 10:15
Can I just welcome you to the Inquiry and thank you very much for making a statement, which is now going to be read so if you listen carefully. I'm sure you know it pretty much backwards by now but if you will just listen carefully and then you will be asked to confirm 10:16
that that's the statement you want to make. All right. So welcome to you, welcome to your daughter and we will now hear the statement read.

P34'S MOTHER'S STATEMENT READ: 10:16

MS. KILEY: I should say, Chair and Panel, you will see that the witness is accompanied by her Family Liaison Officer who is known to the Inquiry.

CHAIRPERSON: Yes. 10:16

MS. KILEY: Mary, good morning again, you and I met briefly earlier this morning, and I explained the procedure that we'll adopt today in giving your evidence. So, as you know, you have made a statement

to the Inquiry and the first thing that I am going do is read that allowed into the Inquiry record. You have a copy in front of you, if you would like to follow along when I'm reading. When I am reading, you will notice that I won't say certain names and instead I will be reading out a cipher and in front of you, you also you have a cipher list so that will enable you to follow on to check who I am referring to if you wish. 10:16

I also explained to you this morning that the PSNI made an application for a Restriction Order in respect of some of the paragraphs of your statement and I have already explained to you what that means, I am not going to go through that again. But the Chair has now made that order. So if I miss over some paragraphs you will know that that's why and we will deal with that later in a closed session. Okay. And are you ready for me now to commence reading? 10:17 10:17

A. Yes.

MS. KILEY: Okay, thank you. So you have made a statement to the Inquiry which is dated the 25th of September 2023 and you say: 10:17

"I, Mary, make the following statement for the purpose of the Muckamore Abbey MAH Inquiry. In exhibiting any documents I will number each so my first document will be Exhibit 1. 10:17

My connection with MAH is that my son, Matthew, was a

patient in MAH. The relevant time periods that I can speak about is March 2005 to 2007, and 2009 to June 2023.

I am the mother of Matthew, who is 29 years old. Matthew spent his early childhood at home with his family, me, his daddy and his sister Jennifer, who is about four years older than him. Jennifer is also providing a statement to the Inquiry. Matthew has a large extended family, he is loved and has always been fully included in the family. I attach at Exhibit 1 a photograph of Matthew. 10:18 10:18

I would describe Matthew as a good baby. He was a very compliant wee boy who slept a lot. Matthew was premature and born a month early via emergency caesarian section. Matthew suffered from reflux at birth which is still present today. Matthew also suffered from a range of breathing difficulties in his first years of life. However, overall he was largely hitting his developmental milestones and was able to walk and babble. 10:18 10:18

Matthew did have some issues with his fine motor skills and engaged in body rocking. When Matthew was two and a half to three years old, me and my husband became concerned as Matthew's speech seemed delayed. Matthew began to show a weakness in his left arm and was dropping things. Matthew was referred to a physiotherapist at the Royal Victoria Hospital in and 10:19

around 1996 and it was suggested that he might have a learning disability. At this stage, we were advised that it was unlikely Matthew would be able to attend a mainstream school. I recall coming out of that appointment crying. It was a shock. Matthew would have been overly social and active. He did seem to prefer the company of adults."

Then, Mary, from paragraphs seven to 12 you describe Matthew's schooling and the challenges that he faced with that and at paragraph 10, you then go on to say that Matthew was diagnosed with autism when he was around 10 years old. 10:19

So I am going to, having summarised those, just pick up the reading at paragraph 13 across the page, where you say: 10:20

"In and around 2003, Matthew attended the Children and Adolescents Clinic at Massereene Hospital in Antrim for assessment. I agreed that a referral would be made for Matthew to the Learning Disability Team as an outpatient of Dr. H50. It turned out that, instead, Matthew was placed under the care of Dr. H40 at Whiteabbey. Dr. H40 doubted the educational psychologist assessment of Matthew as autistic because he felt Matthew was too sociable. Dr. H40 felt Matthew just had a learning disability and was a bit 10:20 10:20

hyperactive. He considered the most suitable treatment was via medication. I cannot recall whether Matthew was on Ritalin at that time. In any event I think Dr. H40 prescribed either Risperidone or Seroquel.

10:21

I recall Dr. H40 advising that if we got Matthew into MAH for assessment for a couple of weeks then he could get back to school. This led to Matthew's first admission to MAH in and around March 2005. When Matthew went into MAH he was age had 11 years old. 10:21
Matthew was placed in Conicar, which was a children's ward. The Ward Manager was H122 who I thought was a lovely man. I remember Dr. H40 told us that Matthew had the "creme de la creme" of staff. I did genuinely think the admission would be for a couple of weeks. 10:21
I recall the admission day and I attended with Matthew's Daddy and his sister Jennifer. I do not remember signing any documents or having any formal introductions but I do remember a Staff Nurse named H551 who was very good with Matthew and was like a 10:21
motherly figure to him.

During this admission, Matthew would have returned home from Friday to Sunday. A teacher also went to MAH from Riverside school in Antrim to assist with education. 10:22
I recall a report provided by this teacher was the first educational report that was positive. The teacher would have taken Matthew to the library. There was also a behaviour nurse called H588 who was very

good and pro-active. Matthew seemed happy at that time. I would visit him and at this point I had no major concerns.

When Matthew was admitted to MAH in 2005 he had mild to moderate learning difficulties, Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder. I know that MAH now say that Matthew has severe learning difficulties, which I believe is due to his poor treatment over the years, and bipolar disorder. However, I dispute this bipolar diagnosis. 10:22

Matthew has also been diagnosed with a heart condition, Long QT Syndrome 7. I do not know if this was something Matthew has had since birth, it was not diagnosed until some years later or if the medication Matthew has been continually prescribed has induced this. 10:23

The consultant treating Matthew in MAH was Dr. H49. As a consultant, I found her hard to communicate with. She would not provide much information or updates on the assessment process. 10:23

Matthew was aged 12 years when he was discharged to home. He returned to Hillcroft School. Upon discharge, Matthew came home for about 18 months and during this time, I believe he was on some other medication. We had gone away as a family to Donegal that summer and Matthew was not great. I could see 10:23

Matthew declining and he would have been bed-wetting. He had put on weight and would have presented as unpredictable. I felt this was medication-related as it was not a presentation Matthew had displayed in the past. 10:23

In or around November 2007, close to Matthew's birthday, Matthew's Daddy had taken him to a football match and Matthew had become a bit agitated at the football. When Matthew returned home, he lost control. 10:24 He pulled curtains down, knocked pictures off the wall and kicked out at his sister. This was never before Matthew's presentation. I telephoned MAH to say I needed help. They said that they could not do anything as he had been discharged. I then telephoned the 10:24 out-of-hours social worker who eventually came out to the house. An out-of-hours doctor attend and gave Matthew more medication, which was again a benzodiazepine drug. This made things worse again. Contact was then made with Dr. H50 who said that there 10:24 were no beds in MAH and suggested an appointment. Eventually, MAH conceded that Matthew needed emergency admission. Police were in attendance. Matthew was taken by ambulance and I accompanied Matthew in the ambulance with him. There was no need for restraint, 10:24 Matthew went like a lamb. I did not want this by felt I had no choice.

Matthew was admitted at about 3:00 a.m. to Cranfield 1,

which is a male ward. It was explained that this was because there were no beds available in the children's ward. I was unaware of the arrangements that were made for Matthew in recognition that he was only fourteens years old and being placed on an adult ward. I do believe that Dr. H40 was of the opinion Matthew required one-to-one care whilst in the adult ward and this was provided. 10:25

Matthew was formally detained under the Mental Health Order by a doctor at MAH. This was not explained to me at the time but I did understand that this meant Matthew could not leave MAH. I was not given any literature or brochures when Matthew was admitted or detained. No-one ever took the time to explain the process of admission or detention to me. I thought it was for Matthew's own protection and I did not understand that it gave powers to MAH. I would have visited Matthew with family about three or fours times a week and at weekends when he was in the adult ward. 10:25 10:26

After about three or four weeks, a bed was available in Mallow. Mallow was a children's ward and I felt this was an appropriate transfer. Although Matthew was moved between wards, I am unaware of any risk assessments related to these moves. 10:26

There was a different ward manager for Mallow at this time called H397. Whilst Matthew was under his care,

for reasons I am unaware of, Matthew's previous behaviour nurse, H588, was unable to work with him. I found this unfortunate as Matthew had worked very well with her in the past.

10:26

My family were never really allowed onto the ward. When we visited Matthew during his time on Mallow, we could see he was deteriorating and I understand there was complaints about his behaviour. I recall an incident in and around 2008 about which I made a 10:26
statement to the police on the 10th of February 2009 which I attach at Exhibit 3 and the contents of which I wish to adopt as part of my evidence to the Inquiry. A file was sent to the PPS about that incident but I later received a letter to advise there would be no 10:27
prosecution. A multidisciplinary team meeting took place about this incident involving the police. However I was not invited to this. I am unsure if H578 was sacked or otherwise left. However, I did not see him again after this. 10:27

I recall a one-off children's party in MAH around 2008 or 2009. I have a fond memory of Matthew recognising the staff member H600 that was in disguise as Santa for the children. I also recall Matthew running back and 10:27
forth towards H578 at this party and he was laughing. Reading the situation now, I think Matthew was indicating that H578 could not harm him whilst his family was present.

I had many concerns regarding Mallow. There was another incident when there was insufficient staff due to an emergency. As a result, a nurse locked Matthew in the bathroom on his own. I felt the management of Mallow was not up to scratch. I recall being told at the time that the staff member involved was put on supervision.

10:28

In 2010, Matthew was transferred to the Iveagh Centre. Ivy opened on 26th March 2010 as a specialist facility for the diagnosis of children with mental health issues and disabilities. Mallow had closed and Matthew was transferred to Ivy when it opened. I cannot recall being shown any risk assessment for Matthew's transfer to Ivy or any transitioning work being done with him. There was no gradual transition. It was just a matter of moving the children to Ivy to get them away from Six Mile which was a forensic ward. That is what the manager at the time told me.

10:28

10:28

The same MAH management was transferred from Mallow to Ivy including H397. I visited Matthew several times a week and did his washing. Matthew had started to go to Glenn Craig at this time. Glenn Craig was a daycare education centre. Matthew would also have come periodically at this time.

10:29

Matthew's behaviour deteriorate had even further at

Ivy. Environment is so important for well-being and I felt Ivy was unsuitable. Ivy is in an urban setting as opposed to Matthew's home and MAH. There was nowhere to take Matthew for a walk. It became harder and harder to take Matthew home. I do not feel that Ivy met Matthew's needs. 10:29

On the 12th July 2011, there was rioting around Ivy. I saw the news reports on television and I was extremely worried about Matthew. I telephoned Mencap and The Stephen Nolan Show as I was concerned that Ivy was not a safe environment. Matthew was just shy of his 18th birthday by this stage and would not be able to stay in Ivy once he was 18 years old. I asked Dr. H40 could they transfer Matthew back to MAH for assessment and treatment. Dr. H40 agreed for Matthew to be moved back to Cranfield 1 before his 18th birthday with support of extra staff due to him being in an adult ward. 10:29 10:29

I understood this was to be one-to-one care for Matthew due to the circumstances. I was not happy with Matthew remaining at Ivy at this time and I was happier with the move and assurances in relation to Cranfield. 10:30

Dr. H40 lifted the detention on Matthew when he was 18 years old and so Matthew became a voluntary patient. Matthew started to improve and then he was moved to another ward called Killead in about 2012. Matthew had 10:30

been assessed and treated in Cranfield 1 and I understood he was being moved to Killead in preparation for discharge resettlement. Matthew's time in Killead was disastrous. Killead was an open plan ward with older men just sitting about. Matthew's behaviour deteriorated and he tried to run out of the ward any opportunity he had. I feel he was trying to escape this environment, which he was unhappy in as there was no stimulation. 10:30

Whilst Matthew was in Killead he was under the consultant, Dr. H49. After approximately two months of Matthew being in Killead, I approached Dr. H49 about my concerns regarding Matthew's environment and behaviour. However, I felt she was dismissive and not very helpful. 10:31

I then went, with the support of Matthew's sister, Jennifer, to see Dr. H40, Matthew's previous consultant from Cranfield. I raised the same concerns with him and requested Matthew be moved back to Cranfield which Dr. H40 agreed to. Matthew had deteriorated to the extent that when he was moved back to Cranfield 1 in mid 2012 he would not get out of bed. 10:31

I cannot recall seeing any risk assessments or plans related to Matthew's moves between Ivy, Cranfield 1 and Killead, nor was I aware of Matthew being prepared for the differences between those wards and his life on the

wards. My family trusted that staff in MAH knew best and we are now saddened that our trust was betrayed.

In 2013, there was an incident in relation to an outing to Glenn Craig. Matthew had not slept and had fallen asleep at around 6 am. Despite this, the Cranfield staff got him up an hour later to send him in a taxi to Glenn Craig. After he had left the staff realised that Matthew had not been given his medication so he had to be returned so he could take it. During the journey Matthew felt sick and had to stop at the Culloden Hotel where he vomited. I understand Matthew had a very difficult day at Glenn Craig and was agitated and hitting out. Matthew was collected again by taxi to go back to MAH and his level of agitation in the taxi resulted in him being taken to Holywood Police Station. On arrival, the police surrounded the car and Matthew was struck on the arm with a baton. The Glenn Craig staff came on the scene and told the police to back off. I spoke to the sergeant in Holywood about my upset and dissatisfaction in relation to this incident and was advised that this could be reported by the Police Ombudsman. I did not follow this through as I was not advised on the process of how to do so and I was extremely stressed about the matter. 10:32 10:32 10:32 10:33 10:33

I do not feel that it was appropriate for MAH to send Matthew that day to Glenn Craig due to his lack of sleep and the delay in administering his medication.

I believe some one should have undertaken a risk assessment on whether Matthew should go to Glenn Craig. The bottom line is Matthew should never have been taken out of bed that morning to go anywhere.

10:33

I understand the day after this incident there was a meeting and a Glenn Craig staff member attended along with the consultant Dr. H40, Social Worker 2 and another member of MAH management. I do not believe this incident was taken seriously or dealt with appropriately.

10:33

Around this same period of time, Matthew was not happy and was completely unsettled. I was going up three to four times a week to visit him in MAH. Matthew was not getting out of bed on the ward until the evening time. I think this suited the staff as it was one patient less to care and support.

10:34

There was also a period when Matthew was not sleeping. He was very restless. His medication was being adjusted all the time to try and deal with it and I am concerned about the effect of that on his brain. It now distresses me, with knowing what I know, that Matthew's unhappiness and unsettled behaviour may have been indicative of him being abused.

10:34

Matthew did not have self-injurious or self-harming behaviour when he was at home, nor did he show

aggression towards others. He was always happy when people were happy around him. I believe Matthew developed this aggression whilst in MAH.

It was around this time in 2013 when I just felt something was not right in MAH. I do not know what was making me feel that way. I was afraid and it was starting to really impact my mental health. Matthew would have told me certain staff members were bad. I would try and reassure him and I would tell him I was going to speak to the doctor about this but then he would say no, they were not bad. I believe Matthew was afraid of the consequences. 10:34 10:35

During MDTMs, Matthew's unsettled behaviours were being report by nursing staff on the ward and subsequently Matthew's medication was being changed regularly. It is my belief that some of the nursing staff involved in reporting Matthew's behaviour at these MDTMs were alleging abusing Matthew based on the names and allegations Matthew has since communicated to me and his Daddy. 10:35 10:35

I was also concerned about the overuse of PRN. My understanding was that PRN medication should have been used as a last resort, not as an easy and convenient intervention. I noticed there to be a pattern of increased use of PRN associated with a certain core of staff. I did raise this at one of the MDTMs. 10:35

I remember Matthew was placed in the seclusion room on

numerous occasions. I did not know what it was initially. At this time I did not even see Matthew's bedroom in Cranfield, let alone the seclusion room. MAH staff never really described what or why the seclusion room was used. I was just told it was for deescalation. I was never provided with any procedures or guidance governing its use. In my head, and because MAH staff had reassured me that Matthew was fine and that staff would have been outside the door, I had a false sense that it would have been a nice room. 10:36

I recall that on one occasion during a telephone call to the ward, I asked was Matthew back on the ward and was told that he was still in seclusion and was banging on the door. This was very distressing to hear. I was led to believe that this was an appropriate facility. However, I now feel that some staff used it to punish patients or for their own convenience. 10:36

In early 2018 I recall visiting MAH and hearing a lot of hammering. I asked what it was and I was informed MAH were doing the seclusion room up. I understand the seclusion room looked much different following this renovation. 10:37

Whilst in MAH, Matthew's physical appearance was very poor on a lot of occasions. Sometimes Matthew would come out wearing other people's clothes and shoes. I recall Matthew's clothing being ripped, specifically 10:37

around the neck, and when I questioned this, I was told that it was related to the washing machine, although I did a lot of Matthew's washing at home, or he was ripping his clothes himself. I found this astonishing as this was never a behaviour Matthew displayed at home. On occasions, Matthew would also be presented wearing clothing inside out. 10:37

Matthew has always required support with every aspect of his personal care. I recall during a family visit, I brought buns to the Cosy Corner. Whilst eating them, Matthew's Daddy noticed had and was disgusted at the dirt in his nails. This appeared to be faeces. We returned right away to the ward and raised this discontent with a nurse called H591. I was very upset at her dismissive manner and when I mentioned that I was aware there had been several outbreaks of Norovirus, that Matthew had been a victim to, she became very defensive. The member of staff that was supposedly caring for Matthew that day was called H592. He was very curt with myself and my husband for around one year after we raised this issue. After this incident, I always carried a nail brush and scissors in my bag to cut Matthew's nails." 10:37 10:38 10:38

And then if you turn over to paragraph 58.

"Matthew was happy when he came home for visits. However, his motivation at that time was not great.

I would have arranged to take Matthew out in the car a short walk or for a visit to family to try and lift his mood. As far as I am aware, at this time around 2014, no activities were arranged by MAH for Matthew. Looking back now, MAH generally were not concerned with the physical health of Matthew.

Another issue of concern was Matthew's teeth and dental hygiene. Matthew had developed a bad infection in his tooth. It was obvious to me that something was wrong as he had a very swollen face at his jaw. Matthew must have been in a lot of pain. I asked the staff to arrange an appointment with the dentist and Matthew was prescribed an antibiotic.

Right up to the present day, brushing his teeth has remained an issue. This was raised all the time at visits as it was clear Matthew had not been getting support to brush his teeth. I brought a toothbrush and toothpaste with me to visits. Throughout his time at MAH, Matthew had various dental procedures including two extractions and seven new fillings in May 2023, seven fillings in July 2021, as well as having other teeth extracted on other occasions. I recall another time during a visit when I spotted black in Matthew's teeth. That was decay and had to be removed. It was very clear to me that MAH staff were not regularly brushing Matthew's teeth. This was the level of basic care that was lacking.

Somewhere around 2021 when MAH began doing physical health checks on the patients, I was informed that Matthew had a small swelling in one of his genitals. This concerned me. However, I was reassured by the Deputy Ward Manager, H415, that it would be monitored. During monitoring in 2022, it was thought that this swelling had become more evident. As a result, Matthew was seen by Dr. H242 who is a GP with the Belfast Health and Social Care Trust. Doctor H242 referred Matthew for an ultrasound in Antrim Area Hospital where it was concluded that Matthew had what was known as a hydrocele. Based on a patient information leaflet sent to my daughter Jennifer in an e-mail from Dr. H242 that I have attached at Exhibit 5, hydroceles are generally uncommon and one of the potential causes can be an injury. 10:40 10:40 10:41

Some staff had an inappropriate way of speaking with Matthew, if he did something jokingly like touch a staff member on the bottom. Matthew would have exhibited this behaviour for a while, but rather than dealing with this in a mature and professional fashion, staff would have said: "Don't touch what you can't hold in your hand". I felt this was a strange almost sexualised way to speak to a person who did not appreciate or understand this kind of language. 10:41 10:41

I clearly recollect an upsetting conversation with a

concerned staff member during a visit with Matthew in early 2023. Matthew had requested a glass of water and the staff member working with him promptly responded to get it for him. When the male staff member returned with the water, he seemed upset and informed me that when he asked his colleague for Matthew's water through the locked door in the pod, a female member of staff had said to him: "They don't always get what they want." He then said to me: "Water doesn't cost anything, and none of us will ever know when we need someone to care for us." 10:42 10:42

He was one of the few very compassionate and caring members of staff I have come across in MAH. I am not aware if my presence was known by the female staff member but this was very disturbing to hear and it led me to question if Matthew was refused something as basic as a glass of water, what other ways was he being neglected. I always felt a sense of sadness and helplessness when leaving Matthew after a visit and felt that I was letting him down by leaving him there. 10:42 10:42

Over, the years Matthew has had access to several mobile phones which I had purchased for him to allow him to call and speak to his Daddy and me each evening as part of his nightly routine. However, on numerous occasions this did not happen and when I questioned staff on why Matthew had not called, I was generally told that the phone needed charged or the phone charger 10:43

could not be found. As a result of this, Matthew missed out on his family telephone calls which were extremely important to him to get reassurance from his Daddy and me.

10:43

There were other items we bought for Matthew over the years such as a CD player, radio, WII, Play Station, and expensive aftershaves which went missing, or you would smell the aftershave on him once or twice and then it would be gone. Staff also never engaged with 10:43
Matthew in using any of these items and when we asked where they were, we were told they were broken or staff said they were not sure where they went, but we would never have seen them again. This is also why I would only leave in what Matthew needed and when he needed it 10:44
as I did not trust the staff.

Matthew stayed in Cranfield 1 until June 2017 when he was resettled in a residential facility providing specialist services and which is operated by the Priory 10:44
Group. During this resettlement, H593, who was a behavioural specialist in MAH, worked intensely with Matthew. H593 had worked previously for several years with Matthew, initially as a Staff Nurse and then in the behaviour team. She had a really positive impact 10:44
on him and he was thriving with her input. H593 would have taken Matthew out for dinner to forest walks, and she brought him to our family home every week for lunch. H593 was a Lifeline to Matthew in MAH.

In September 2017, when Matthew was beginning to settle in the resettlement facility, I received a telephone call from H411 within the safeguarding team at MAH. H411 said that they were investigating an incident involving Matthew in a swimming pool four or five years previously. No details were provided and five months later, H411 called back to say there was nothing to this. I do not know what the alleged incident had been or how Matthew was said to be involved. I found the whole matter very concerning. 10:45 10:45

On the week leading up to Christmas 2017 Matthew was physically unwell with cold and flu-like symptoms. Bu the middle of the week, Dr. H599 had stopped Matthew's Clozapine medication immediately, due to three red flag blood results that showed he had abnormally low levels of white blood cells, Neutropenia. I was only made aware of his cessation of Clozapine 48 hours later by a support worker in the resettlement facility. Dr. H599 had not informed me of this. 10:45 10:45

We had planned to have Christmas dinner at Matthew's sister house with extended family. However, in the early hours of Christmas morning, Matthew was admitted back to MAH. His cold and flu-like symptoms had got worse and I was informed that Matthew was presenting with strange behaviours, for example, trying to step over walls that were not there. In hindsight, this 10:46

sounds like Matthew was delirious, which in my view may have been the result of abrupt medication stoppage or underlying infection as a result of his low levels of white blood cells.

10:46

Matthew was in MAH for about five days before a doctor decided to get Matthew an emergency admission to Antrim Area Hospital due to his physical health deterioration. All of Matthew's medications were then stopped. He had developed pneumonia and flu. I remember Matthew was 10:46
moved to the flu ward. My daughter, Jennifer, and her husband visited Matthew there and she was told that he may need to go to ICU to let his body recover. Thankfully, he started to respond to treatment and this was not required. I feel that if Matthew had have been 10:47
taken to Antrim Hospital on Christmas morning rather than MAH, he may not have gone on to develop pneumonia and flu.

I remember this time vividly as Matthew described his 10:47
time in Antrim Area Hospital as the time "the sun came out". To this day, he still recollects being in Antrim Hospital when "the sun came out", I believe this is where he felt safe.

10:47

On discharge from Antrim Hospital Matthew returned to MAH for several days before moving back to his resettlement facility. He was there only for a short period before he had to return to MAH due to what I can

only recollect as being withdrawal side effects from the abrupt stopping of medication. On his return, he was initially placed in Cranfield 1 but subsequently moved to PICU a short time later. When Matthew moved to PICU, I felt this was a positive move as I was informed by MAH that this ward had a smaller number of patients and was for more Intensive Care. I believed this would make his return to the resettlement facility happen more promptly. I was not aware at this time that there had been abuse in Cranfield or PICU. During Matthew's time in PICU, H593 became involved with him again in terms of behavioural support. Things started to look more positive with her input until early Autumn when I began noticing that a lot of regular staff were no longer around and agency staff were starting to appear. I suspected this was having a detrimental effect on Matthew's behaviour at the time. I believe it was around this time that I became aware of the alleged abuse in PICU prior to Matthew being there. 10:47 10:48 10:48 10:48

In subsequent years I have also become aware that Matthew had been started on Haloperidol in August 2018 which was increased to the maximum dose of 20mg by November 2018. I feel the introduction of this anti-psychotic medication may have played a key role in Matthew's mental health deterioration and that it still continues to do so. 10:48

Matthew had remained almost entirely in MAH from December 2017 to March 2019. Although Matthew was in MAH from December 2017 he still had a placement in the resettlement facility which was being paid for. It is my understanding that staff from the resettlement facility were therefore supposed to come to MAH and work with Matthew. However, they did not come frequently enough or for long enough periods and did not work closely enough with the staff who were caring for Matthew in MAH at the time. Instead, they seemed to come to MAH only on a rare occasion. This was not just my own perception as staff in MAH also indicated that this was the case to me and at least one Staff Nurse expressed sympathy to me about this. 10:49 10:49

The failure to undertake sufficient work with Matthew in advance by the resettlement facility staff was one of the key reasons the placement ultimately failed.

By March 2019, a locum consultant pushed for Matthew to go back to the resettlement facility on the basis that if the placement was not again attempted at that stage it would never happen and the family would never know if it would have worked. An attempt was therefore made at that stage to try the placement again. 10:50 10:50

When Matthew went back to the resettlement facility in 2019, the behaviour team from MAH, who continued to engage with him for a while, soon advised that the

placement was not working. I believe that a key reason for this was a lack of familiarity between Matthew and the staff in the resettlement facility. I think the fact that staff for the resettlement placement had not been coming to Matthew and working with him alongside the staff in MAH regularly over an extended, prior to the placement beginning, undermined the possibility that the placement would succeed. Matthew ended up paying almost £500 a month out of his ESA for the resettlement placement during the period December 2017 to March 2019 and as ESA was his only benefit or income, this left him only £20 per week for anything else. 10:50 10:51

In and around March 2019 the proposed placement ended due to a deterioration in Matthew's mental health and this required a reassessment. 10:51

I do not feel that Matthew had been properly prepared for his re-transition from MAH to the resettlement facility. Also, there were other issues with the placement. By way of example, when Matthew returned to the resettlement facility, he was sharing the unit with a female who self-harmed by banging her head off the walls, which I believe was distressing for Matthew to witness. When I spoke with management about the incompatibility of Matthew and this other female resident, I was simply told that they needed to fill the beds. 10:51 10:51

Matthew was readmitted to MAH where he remained until May 2023 when his transition to supported living in the community commenced."

10:52

And then picking up paragraph 90, you say:

"In January 2022, I initially contacted the ward to advise that I was on my way to visit Matthew. However, the staff member informed me that Matthew had come from his own living space which was referred to as a "pod" and was now in the day space in which he was refusing to leave to return to his pod. The staff member told me that she did not think our visit was advisable as Matthew was unsettled. I informed her that I believe the visit from his family would settle him down so we proceeded to visit and as I suspected, seeing his Daddy and I helped Matthew to settle. Whilst the visit was a good one for Matthew, it was extremely difficult for his Daddy and I as it was the first time we had ever seen Matthew's living condition and it gave rise to significant concerns about Matthew's care.

10:52

10:52

10:52

Following the visit that day we both returned to our car in silence and cried at the thought of our son being confined to those horrible conditions for so long.

10:53

The environment in which Matthew lived in

MAH was a separate pod. This was arranged when Matthew had been in Cranfield 1. Staff said that several safeguarding issues had been raised against Matthew because he was getting in people's faces and they said he had to be moved to the pod where he could regulate himself. At that time, the staff had painted a picture of the pod as an attractive space that would be his own but it would also allow him to go up and down to the day space when he wanted. My daughter, Jennifer, has also provided a statement to the Inquiry and will be providing further information on the pod. 10:53 10:53

I believe Matthew spent most of his time isolated from other residents in the pod and seemed very frustrated as a result. It was not positive. Matthew was behind locked doors. Although Matthew had a small TV in a box in the pod, when we visited the TV was off, nor was there any music on. There was no pillow on his bed. Matthew had also thrown his clothes and slippers up to where there was a pitch in the ceiling and no-one had taken them down. The area was depressing. The walls were blank and colourless. It was grubby and never smelled clean. It appeared more like solitary confinement than a living environment for someone with a proper quality of life. 10:53 10:54 10:54

Prior to us being able to visit Matthew in the pod, we would have had our visits in the Cranfield visitors room. The staff would not bring Matthew through the

ward. Instead they would have walked him right around the outside of the building no matter what the weather was like and they would have said the ward was unsettled, which is why they did this, but I did not believe them. I believe this was simply to prevent Matthew from gaining access to the ward. Matthew would have got anxious at the end of our visits as he knew he had to go back into the pod again.

I recall times myself and my husband would have had to wait a long time to see Matthew, up to 30 minutes on occasions. I also recall being left waiting outside in the rain to gain entry to the pod once we were permitted to have the visits there. I believe these delays were possibly due to staff getting Matthew cleaned and dressed appropriately. On one occasion, a female staff member informed me during a visit that she had seen Matthew in a bad state of hygiene that morning. He was not in her care at the time. However, she went out of her way to get him showered, shaved and changed. She wanted to do this as she did not like to see Matthew in that state. This was positive to hear and I was so grateful to see a member of staff have a genuine respect for Matthew. This was not common.

In comparison, on another occasion whilst we were visiting, Matthew was soaking right down to his socks in urine. The staff member working with him just changed his clothes without even washing or showering

him. I had to insist that he was taken for a shower which they then did in the end.

It is very important for Matthew to be familiar with those who are caring for him. During a visit in January 2022 we did not recognise the member of staff who was with Matthew throughout the visit. I asked Matthew his name and he said he did not know. The staff member did not introduce himself to us and did not speak a word to us or Matthew except when Matthew got excited and ran towards him. At this point the staff member said: "Get away", as though he was frightened. This reaction made me feel very sad. He responded to my son as if he was a danger to him. I do not think it was appropriate for Matthew to be cared for by someone unfamiliar to him." 10:56 10:56 10:56

At paragraph 99, you say:

"In June 2020 the prospect of resettlement had been raised by the Northern Health and Social Care Trust Resettlement Social Worker for Matthew and a placement was identified with Inspire in Mallusk. No timescales were confirmed and progress seemed very slow. I do recall the Inspire Director showing me around Mallusk in June 2020 just at the height of the pandemic. On 13th August 2021, the Resettlement Co-Ordinator telephoned me to update me on Inspire's difficulties with staff recruitment and delay with the Inreach 10:56 10:57

services. This was very disappointing.

On the 22nd of September 2021, the resettlement coordinator telephoned again about the ongoing recruitment issues. I expressed concern about Matthew remaining in MAH due to the ongoing Covid restrictions which were limiting our visits and access to him and the fact MAH was becoming heavily reliant on agency staff. 10:57

Also, most importantly, Matthew was still living in the environment that he had been allegedly abused in.

On 22nd October 2021, given the absence of any confirmed dated or progress for Matthew's resettlement from MAH, I issued judicial review proceedings on behalf of Matthew against The Northern Trust. 10:57

Throughout the rest of 2021 the resettlement co-ordinator would update me from time to time on recruitment issues in the proposed placement. The judicial review proceedings subsequently resolved by agreement on 8th March 2022 which was based on transition work for Matthew's resettlement to Mallusk starting on 31st October 2022 and expected to take between six and 12 weeks. 10:58

At the beginning of 2022, my daughter, Jennifer, and I raised concerns about the plan for Matthew's care and

resettlement. We asked what services would be supporting Matthew during his transition as there was currently no occupational therapist, behavioural support or physiotherapy allocated. I advised that Matthew had been badly abused and I felt it was important for him to have access to a psychologist. The response I got from Matthew's consultant at that time, Dr. H253, was that she was not in post at the time of the allege had abuse. We had to insist for over a year for support provisions to be put in place for Matthew and even when they were, they were at a minimal. 10:58 10:58

I recall in March 2023 the RQIA did an unannounced visit at MAH. I was only aware of this at the time as I had been advised by another patient's mother. 10:59

Following this, I contacted the RQIA and asked if they saw Matthew's living conditions but I was advised they were following the same patients they had looked at the previous July 2022 so they did not have Matthew on their radar. The woman from RQIA did advise me that they had actually been at the door of the pod. However, they were told the patient currently had visitors. She said that the RQIA representative asked for a message to be relayed to the family to let them know they had been there and if we wanted to contact them, we could. This was never relayed to me by MAH staff. 10:59 10:59

During the same telephone call, I begged that RQIA revisit and specifically go and see the pod.
To my surprise, RQIA did attend again just two days later. The following day, we had a planned MDTM and my 11:00
family had the support of Gerry Kelly MLA in attendance. Matthew was subsequently moved from the pod to the main Cranfield 2 ward the following week.
I believe the MLA presence, along with the visit from RQIA, may have influenced this move as we and family 11:00
had begged for Matthew to be moved from the pod for over a year.

Matthew moved to Mallusk on the 1st June 2023. During the month of May, when his transition began, Matthew 11:00
would have visited Mallusk for anywhere between 30 minutes to two hours. This was not a daily occurrence until later in the month.

On the 1st June 2023, Matthew was taken down to Mallusk 11:00
with a member of staff from MAH that he liked. Matthew was asked if wanted to stay the night and he did. He also then stayed again the following night. It was unfortunate when my husband and I went to visit on the third day Matthew was very unsettled and wanted to go 11:00
back to MAH. This request did not happen. Although I wanted Matthew out of MAH, I feel the way his resettlement has been handled is all wrong. It should have been at Matthew's pace, which was promised to us

as family by the Northern Trust Resettlement Team. However, this has not been the case.

Although MAH have said what Matthew was fit for discharge when his transition began, we, as a family, feel that his presentation presentation at this stage was one of the worst he has displayed. We are putting this mainly down to the multitude of medication he has been on. For example, he is currently prescribed two anti-psychotics and two mood stabilisers, amongst other medications, to counteract the side effects of these. Matthew has spent three years in seclusion in a pod not fit for purpose. 11:01 11:01

There has been a pattern of incidents which arises from Matthew's medication and I do not accept that proper monitoring of Matthew's medication ever occurred whilst at MAH. I was not aware of the amount of medication Matthew was on and I do feel if he had been resettled in mid 2018 when he was presenting much more settled, he would have flourished at that stage. 11:01 11:02

Although the resettlement to Mallusk is in its early days, we as family are relieved he is now out of MAH and we are hopeful that with this change of environment and with good support staff working with him, he will flourish. 11:02

My daughter, Jennifer, and I had sight of a Northern

Trust Care Plan and Positive Behaviour Support Plan around May 2023 and I attach these documents at Exhibit 6. They were provided to us for review by members of The Northern Trust Resettlement Team. These plans were based on what was used in MAH. It was the first we as family had ever seen any care or behavioural plans for Matthew. My daughter, Jennifer, and I have had to go through these documents and make extensive changes to update inaccuracies and outdated information. I have attached our edited versions at Exhibit 7." 11:02

And at paragraph 111 you say:

"Matthew has been let down at every stage of what should have been assessment, treatment, and care, no less than the professional standard of care for a vulnerable person within a specialist hospital, along with full compliance to the policies and procedures that should have ensured that standard was met. 11:03

The Belfast Trust has apologised to all patients and their families who have been involved in the allegations of abuse and mismanagement at MAH. The Belfast Trust and the Northern Trust have, however, continued to let Matthew down over the arrangements for his resettlement from MAH. He was left in MAH where a culture of abuse was allowed to develop and where he had been abused. It took a judicial review to expedite his resettlement. 11:03

The lack of meaningful preparation to ensure a successful transfer to a suitable facility is an important issue as the consequences of a placement failure were not only serious for Matthew in terms of his health and an unnecessarily prolonged stay in MAH but it also affects the likelihood of a successful transfer to an alternative facility. 11:04

I feel like some therapeutic support or intervention should be provided to patients who have been abused. In my view, Matthew requires an independent assessment as to the impact of the abuse on him and that this should be funded by the Belfast Trust. 11:04

Matthew has been identified as being abused from day 1. MAH should have had Psychology involved and he never should been secluded in the pod. I feel as though Matthew was punished a second time and was at the mercy of whoever he was in the pod without the protection of CCTV. 11:04

My biggest regret is the day that I ever let Matthew walk through the gates of MAH. I feel he is not, nor will he ever be, the same person after what he has endured in MAH. His Daddy and I honestly believed that he would be going in for a few weeks of assessment but how wrong we were. We feel it is a life that has been lost and we now want to make this up to Matthew. We hope he can get the best possible life going forward in 11:04

his new home in the community.

This has been one of the longest and hardest roads for Matthew and my family and I just hope no other vulnerable person suffers similar maltreatment and that life would be kinder to people with a learning difficulty in the future."

Then, Mary, you have got seven exhibits to your statement which I'm not going to read out aloud but the Panel have all of these. Mary, having heard me read that part of your evidence, are you happy to adopt your statement as your evidence to the Inquiry. 11:05

A. Yeah.

1 Q. And in your statement, you refer to your daughter, Jennifer, and Jennifer has also made a statement to the Inquiry, and is it right that you have nominated Jennifer to give your family's evidence to the Inquiry about your experience at Muckamore? 11:05

A. Yes. 11:06

2 Q. And there is nothing else that you wish to say to the Panel at this stage then, is that right?

A. No.

3 Q. Okay.

CHAIRPERSON: All right. Mary, thank you very much, you are going to be come back a little bit later but I don't think you will be very long until that happens. I just want to thank you for that so far. I know you found it difficult just to be here and to listen to 11:06

that, and I think we can all understand why. We have been going just longer than hour. Would you like a bit of a break, I think, because the next witness is about 20 pages so what we can probably do is if we take the break now and then we can have the next witness plus the two parts that are under the restriction orders. Would that make sense? 11:06

MS. KILEY: Yes, I think so, thank you, Chair.

CHAIRPERSON: So we'll take a 15 minute break now and then we'll start again at about 25 past. Thank you very much. 11:07

SHORT ADJOURNMENT

11:07

THE HEARING THEN RESUMED AS FOLLOWS AFTER THE SHORT ADJOURNMENT

CHAIRPERSON: Thank you. Welcome, Jennifer, thank you very much for coming along to assist the Inquiry and you're about to be sworn.

P34'S SISTER, HAVING BEEN SWORN, WAS EXAMINED BY MS. KILEY AS FOLLOWS:

11:32

4 Q. MS. KILEY: Hi, Jennifer. We met earlier this morning and you've now heard your Mum's statement be read aloud, so I won't go over all the procedures again, you've seen how it's done, and I see that you have a copy of your statement in front of you and there is a cipher list there also if you want to refer to it. So if you're ready, what I will do is start reading your statement and then the only difference between what happened this morning with your mum is that after I have finished reading your statement, I do have some questions that I will ask you. Is that okay? 11:32

A. Yep.

5 Q. And are you what ready for me to start reading? Okay, thank you. So your statement is dated 25th September 2023 and you say: 11:32

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

My connection with MAH is that my brother, Matthew, was a patient at MAH. The relevant time period that I can speak about is from 2007 to June 2023. I am the older sister of Matthew and the daughter of Mary and Jackie. My mother, Mary, has also provided a statement to the Inquiry. I seek to address those issues in which I have had specific dealings. 11:33

To give some context on Matthew's life prior to MAH, he had mild to moderate learning difficulties, Attention Deficit Hyperactivity Disorder, and an autism spectrum it disorder. That did not prevent him from being loved by all of us and included in family activities. 11:33

Matthew was always overly social and active. I have many happy memories of when our Daddy took us both to football matches, on mountain walks, to the park and walks around lakes where he went fishing. Matthew was more than capable of engaging in such activities and got plenty of enjoyment from them. 11:33 11:34

We have a large extended family and Matthew was, and still is, fully part of it. He loved family parties where he spent time with the people who loved and care for him and whom he had fun with and enjoyed singing songs with. I remember trips to Donegal with the larger family and how much Matthew loved to be a part of this. I now feel very sad that Matthew is unable to be involved in such family activities and holidays due to 11:34

his significant deterioration from being institutionalised, secluded and allegedly abused in MAH.

In January 2020 Matthew was moved from the main ward in Cranfield 1 to the pod in Cranfield 2. My mother has told me that she had been painted a pretty picture of the pod in that it would be a calming area that Matthew could use to self-regulate. She was also told he would still be able to come and go freely from the main Cranfield 2 ward. I can state with certainty that it was never proposed to us that Matthew would permanently be locked away in the pod with no access to the main ward and secluded from all other patients and staff on the main Cranfield 2 ward. This is what happened until March 2023. 11:34 11:34 11:35

The pod was a closed off area at the end of the bedroom corridor in Cranfield 2. It contained three small bedrooms, one named as a bedroom, one renamed as a living room and one renamed as a dining room. In the living room, there was a small TV, no more than about 20 inches, which sat behind a perspex panel. Matthew is visually impaired, which I believe is a side effect of the medications he has been and remains on, and therefore, would not have been able to see this TV without difficulty. At one stage there was no sofa, just a sloping chair. 11:35 11:35

In the dining room there were no table or chairs to allow Matthew to eat. Instead, Matthew had to eat his meals in his bedroom at a desk space that was part of the built-in wardrobe. My family had to insist on Matthew getting an a sofa and table and chairs. There were no skirting boards or door frames in certain rooms and the walls" were bare, with no decor whatsoever. The rooms were usually dark as window blinds from not opened by the staff. Matthew had a match box sized hole in the window of the locked door to the main ward to look through. 11:36 11:36

Within the pod, there was no access to a garden area or the bath which Matthew really enjoyed. I attach photographs of the pod at Exhibit 1. I feel immense sadness and helplessness when I envisage Matthew living in these horrendous conditions. 11:36

My family only became aware of Matthew's horrendous living conditions in January 2022 when my mother and father were finally allowed into his living area following relaxation of Covid 19 restrictions. After this visit, I remember the very upsetting call I received from my parents. My parents had both been crying due to becoming aware of the conditions Matthew had been living in. From then my family pleaded with MAH senior management to move Matthew out of the pod and into the main Cranfield 2 ward until his planned transition to Mallusk occurred. I continually made my 11:36 11:37

views regarding my thoughts on the pod known to senior management, describing it as a prison, seclusion, and not fit for an animal, never mind a human being.

In or around late summer 2022, we became aware that there were no CCTV cameras in the pod that Matthew was living in, and CCTV may only have been in the corridor area. This was a complete shock to me and my family. We did not believe that there was any area of Muckamore Abbey, except bedrooms and bathrooms where patients were cared for without CCTV coverage, especially after the alleged abuse within MAH. 11:37 11:37

A letter in November 2020 from the MAH service manager at the time, H300, affirmed this belief. The letter stated how CCTV had been in operation in communal areas from March 2017 and that MAH had hoped to expand the use of the CCTV footage and one reason was to increase the trust and confidence for families. I attach a copy of this letter at Exhibit 2. 11:37 11:38

The lack of CCTV cameras in the pod was raised by my family to senior management during a meeting in September 2022 and followed up in numerous later meetings. The safeguarding team also subsequently raised the issue of lack of CCTV coverage in the pod following several safeguarding incidents against Matthew. 11:38

I recall a safeguarding incident over Christmas 2022. During a visit to Matthew on the 31st December 2022, my mother spotted bruising on Matthew's lower wrists. They appeared to her to be fading bruises in the shape of thumb marks. When she asked Matthew what had happened, he told her the person who did it was H625. When he was asked again the next day, he said the same name. There was no management on the ward on these two days so my mother was unable to report this. 11:38

We discussed this as family and after failed attempts to contact ward management on 3nd January 2023, I e-mailed H234, Co-Director, raising my concerns and asking her if she would be available to check Matthew and, in a non-leading way, ask him what happened. 11:39

I understand that H234 went to see Matthew following which she telephoned and e-mailed me to provide an update. She advised that Matthew met her and warmly greeted her and he showed his upper body and upper arms upon her request. H234 advised she saw no bruising or fading of bruising and that he had "wee white circles" on his pale skin. I have attached this e-mail chain at Exhibit 3 and confirm H234 also copied in members of staff, H282 and H415. 11:39

Safeguarding staff H240 and H626 came out to my mother's home on the 11th January 2023 to discuss all open and closed safeguarding events relating to Matthew. We raised this recent incident them. I do 11:40

not feel this incident was dealt with well as it was not investigated any further and in my view it should have been.

During a meeting on the 2nd February 2023 it was acknowledged by MAH Senior Management that the Belfast Health and Social Trust assurance to ensure CCTV in all areas of MAH where staff delivered patient care was not being met in Matthew's case. I attach minutes of this multidisciplinary team meeting at Exhibit 4. 11:40

On the 15th February 2023 during e-mail communications with H626 safeguarding team she informed me that she had been in contact with the Assistant Service Manager, H290, who informed H626 that the CCTV cameras had been installed and connected but she was awaiting confirmation from estates that they were operational. 11:40

I was informed during a subsequent face to face meeting that the cameras were now in operation. Matthew was living in the pod for over three years without CCTV cameras being in place. 11:41

I always dreaded visiting Matthew in the pod. It filled me with great sadness seeing him in this environment and I felt completely helpless having to walk away and leave him there at the end of each visit. 11:41

Prior to my visits my mother would have had to

telephone the ward and let them know we were at the entrance door to the pod which was separate from the main door into Cranfield. The pod entrance was at the side of the building. I remember us having to wait anywhere from 10 to 30 minutes to get into the pod. 11:41
I believe this delay was due to attempts to make Matthew appear more presentable by changing his clothes or removing incontinence pads. Most of the time when visiting Matthew, he was poorly dressed, his personal hygiene was obviously not being maintained and he was 11:42
usually wearing incontinence pads, which my family would have immediately requested be removed.

Following my family becoming aware in January 2022 of Matthew's living conditions in the pod, my mother and I 11:42
requested an urgent meeting with the then Ward Manager, H282, Deputy Ward Manager H415 and Service Manager H300. This meeting took place somewhere between the end of January 2022 and the beginning of February 2022 and included the Deputy Service Manager, H409. There 11:42
were no minutes taken at the meeting. This was the case for all meetings my family had with senior management from January 2022 through to December 2022. I remember members of the senior management team arriving to meetings with post-it notes. I felt the 11:42
meetings were very unprofessional and that there were extremely poor follow-through of actions discussed as nothing had been recorded.

I initiated e-mails with MAH senior management regarding meetings actions, follow-up and my families concerns. I attach several of these e-mails at exhibit five. These are by no means all of the e-mails that I felt it necessary to send. They are a representative sample to indicate how often I had to chase up matters with MAH. My family felt like the major concerns we were raising were not being listened to or taken seriously. 11:43

When actions were not being followed through from the initial meeting that involved the Service Manager, H300, I contacted the then Co-Director for learning disabilities, H627, which led to a formal complaint being recorded. I attach e-mail to H627 dated 1st March 2022 at Exhibit 6. There were only a few e-mails with H627 before I received an out-of-office e-mail from her and after that I had no more correspondence with her and assumed she had left her post. 11:43

On the 22nd March 2022 I e-mailed the Secretary of the Co-Director to request a meeting with the Consultant, H530, the Co-Director, who at this time was H233 and the Cranfield 2 Ward Manager. I was offered to have H234 at the meeting who was at this time the MAH Divisional Nurse which I accepted. I attached a copy of this e-mail at Exhibit 7. 11:44

On 15th July 2022 I e-mailed Dr. Cathy, Chief Executive

of The Belfast Trust, to request a meeting with her to allow my family to share our concerns with regards to Matthew's care in MAH. I detailed that the meetings with MAH Senior Management over the previous six months were unproductive. I attach a copy of this e-mail at Exhibit 8. Dr. Jack proposed that my family meet with the Interim Director, H522, and that meeting took place on the 16th September 2022 with H234 also present. I have no minutes from the meeting and I have no recollection of any actions coming from this. 11:44 11:45

All subsequent meetings involved H234 as divisional nurse and at some stage she was appointed to the role of MAH Co-Director. I had dealt with four senior managers over the period of nine months. It has been very unnerving for my family to see that MAH are unable to retain staff at such senior levels. 11:45

At my family's request, minutes have been taken at meetings since December 2022. I wanted to highlight that I had to follow up on minutes being completed and shared with us. It usually took between six weeks to three months for me to obtain these minutes from MAH. I attach minutes to meetings at Exhibit 9. 11:45

A Family Liaison Social Worker, FLSW1, has been supporting my family since September 2020. In August 2022, when Covid 19 restrictions had been relaxed, we asked FLSW1 to become involved in meetings with MAH

senior management.

FLSW1 has taken immense pressure off my family with her intensive involvement. She is our guardian angel and the most caring, compassionate and trustworthy person I have come across in the health profession. My family would be lost without the support that FLSW1 has provided and continues to provide. 11:46

FLSW4, Family Liaison Lead Social Worker, has also supported the family when FLSW1 has been unavailable. 11:46

On the 6th February 2023, my mother and I presented a letter in person to Michelle O'Neill, First Minister Designate of Northern Ireland. This letter highlighted Matthew's living conditions in MAH, the impact it was having on him, coupled with the fact he had been recognised as a victim of alleged abuse in MAH and the continued delay in relation to his discharge. The letter requested her support. I attach a copy of this letter at Exhibit 10. 11:46 11:47

I also sent a similar letter by e-mail to Carál Ní Chuilín, Nuala McAllister MLA and John Finucane MP on 7th February 2023. These were representatives in my family's local area. 11:47

Sinn Fein, specifically Gerry Kelly MLA, has been supporting my family since February 2023. I feel his

presence at meetings with MAH was key in improving Matthew's living environment and activity plan. Most importantly, in my view, his attendance was the decisive factor for why Matthew's transition was prioritised, initiated and followed through. I believe changes were only made when Gerry became involved and this indicates to me that the Belfast Trust were afraid of potentially receiving more bad media against MAH. I do not think appealing to the politicians should be required to secure proper treatment and resettlement. 11:47

In the past, there were activities organised for Matthew and he had good behavioural support, mainly from H593 who was a behavioural nurse working in Cranfield 1 and PICU. This was a critical element in Matthew's improved behaviour. In 2018, when PICU closed and Matthew was moved to Cranfield 1, he lost the benefit of H593 skills and level of care. She was moved to work in Cranfield 2. 11:48

Until around mid 2018, just prior to Matthew's move to Cranfield 1 and having been prescribed Haloperidol Matthew was at his best, behaviourally. This was after a considerable amount of attention and work with H593. I have provided two photographs at Exhibit 11 to show a comparison how Matthew appeared during that period in 2018 and how he appears now. 11:48

During 2020 when Matthew was in the pod and Covid 19

restrictions were in force I believe Matthew regressed. It should still have been possible to undertake an activities with Matthew, especially within MAH's social bubble.

Matthew was not provided with any behavioural support and our family only became aware of this in early 2022. It took sustained pressure for over one year to reinstate some form of behavioural activity for Matthew. 11:49

Similarly, it required pressure to secure increased daycare and occupational therapy. Efforts to obtain meaningful physiotherapy and speech and language therapy for Matthew was unsuccessful. I cannot understand how it requires such pressure to obtain such basic services for my brother whilst he is in a hospital environment. 11:49

The lack of personal hygiene support that Matthew was provided in MAH was shameful. Matthew's dental record in May 2023 details how he had to have two teeth extracted and had to receive seven new fillings. I remember how past and present, I would have said so staff about supporting Matthew in brushing his teeth. However, I felt they always used the excuse that he would not let them do it. Matthew would have let my mother clean his teeth but I do believe some staff did not take the time and did not have the patience to do 11:49

this for Matthew.

Matthew always loved to look and smell clean but his experience in MAH stripped this from him. More times than not, Matthew would have been wearing clothes that were ripped, inside out or too tight due to shrinking from washing at high temperatures and tumble drying. My mother and I regularly bought Matthew hundreds of pounds worth of sportswear as we always wanted Matthew to look well and be comfortable. I would question if the clothes were being worn by Matthew or if some staff were just lifting the first clothes that came to hand which would have been the last set of clothes washed. 11:50 11:50

We also purchased bottles of aftershave throughout the year for Matthew but I never smelt any on him and when my family questioned why it was not being used, we were often told it had been misplaced. I would not be surprised if it was taken by staff. 11:50

On numerous occasions, our family noticed that Matthew's nails contained faeces. We had to actually ask staff to clean Matthew's hands. Both Matthew's fingernails and toenails have been left over grown. My mother started bringing scissors from home into MAH to cut them. 11:51

Matthew has also had issues with his feet, suffering with bunnions, and it was evident that he was

uncomfortable with these. This had to be raised by my mother, who had to push and insist on an appointment with the pod terrorist.

Further, in respect of Matthew's personal hygiene and grooming, we requested that Matthew was given a facial shave with his electric razor as part of his daily routine. It was evident during visits that there were times when Matthew had not been shaved in several days. Similarly, if this was challenged, staff would fob us off with an excuse such as the charger had been misplaced or lost. 11:51 11:51

It became evident to my family during Matthew's time in the pod that incontinence pads were being used on him. We raised this as a major concern as Matthew was not incontinent prior to being admitted to MAH and we were advised by staff that they were only used at night and on bus journeys. Despite this assurance there have been numerous occasions during visits that Matthew was wearing an incontinence pad. When this has been the case my parents or I would request the pad be removed and we remind staff that Matthew is able to use the toilet. 11:51 11:52 11:52

I believe was down to the laziness of some staff that Matthew has ended up in incontinence pads and we, the family, have been lied to. We actually believe MAH had Matthew in incontinence pads full time. The issue of

incontinence pads is within the handover that was given to Mallusk during resettlement. Mallusk were told by MAH that Matthew wears incontinence pads 24/7. It shows how bad the situation is in MAH with regards to maintaining a patient's personal care when The Deputy Ward Manager at the time, H415, had to put a remainder document in Matthew's bathroom for his daily personal hygiene to emphasise in relation to his teeth that they must be brushed by nursing staff along, with a tick box personal hygiene checklist. I refer to copies of each of these documents at Exhibit 12 and Exhibit 13 respectively. 11:52 11:53

I feel Matthew has been neglected in every aspect of his care in MAH, including his basic personal hygiene. My family disputed Matthew's diagnosis of bipolar according to MAH. In our view, the type of behaviour that was being described and labelled at bipolar could equally have resulted in the various medications Matthew had been prescribed and in response to the trauma he suffered. I am gravely concerned that Matthew was being overmedicated and I raised issues about the overuse of PRN during MDTMs. I have attached a photo of Matthew at Exhibit 14 which shows how he can appear when administered PRN. This is heartbreaking for me to look at in every aspect. 11:53 11:53

He has been left in clothes that have food stains all down them, likely due to him being unable to eat his

meals properly due to being highly medicated. His eyes appear dull and sad and his facial expression is blank. This is not our Matthew.

I asked Matthew's current consultant, H223, what steps should be taken before PRN was used. H223 has been the only one with openness and transparency and advised that there were techniques to identify triggers for Matthew's behaviour and communication steps to deescalate episodes before PRN should be considered. H223 referred to this as the "calm card". My family were never aware of this approach and I have seen no evidence of MAH attempting the calm card approach with Matthew. 11:54 11:54

In my view, MAH was too quick to resort to medication as a way of managing Matthew's behaviour rather than try to understand what was producing the behaviour and dealing with that through alternative therapies. 11:54

The communication between my family and MAH as to exactly what medication Matthew was being given and why was never good. However, it was particularly bad from 2018 onwards. In a 2018 medication review, it was clear that H50 had started Matthew on Haloperidol on 23rd August 2018 as it had been increased to the maximum dosage within three months. These decisions had all been made without my family being notified. I attach a copy of Matthew's 2018 medication review at 11:55

Exhibit 15.

Also on 9th January 2018, H40 prescribed Matthew Diazepam with Lorazepam as PRN first line. An e-mail from H223 on 19th July 2023 which I have attached at Exhibit 16 confirms this. Matthew's behaviour and mental state then deteriorated and he was moved from Cranfield 1 to PICU on 25th January 2018. 11:55

Initially, the dose of diazepam was a low dose but it was subsequently increased significantly on 26th July 2018 and he remained on that for several months despite the fact that it was in his records that he should not be on any benzodiazepines as he is allergic to them. Worst still, the administration of diazepam overlapped with the administration of Haloperidol on 24th October 2018." 11:55 11:56

CHAIRPERSON: Sorry, I think until 24th October.

MS. KILEY: Oh, thank you, I'll re-read that sentence. 11:56

"Worse still, the administration of diazepam overlapped with the administration of Haloperidol until 24th October 2018 when the diazepam was stopped.
H40 was the doctor who told my mother that Matthew was allergic to benzodiazepines even though he himself had also prescribed them to Matthew in later years after telling her this. 11:56
The names of the prescribing clinicians are included in

an e-mail from H223 dated the 11th July 2023. I have attached a copy of this e-mail at Exhibit 17.
I only became aware of what medication Matthew was being prescribed in August 2022 when our family requested this information from the ward manager at the time, H415. 11:57

H223 has also sent Matthew's medication as of the 19th July 2023 to me in an e-mail which I attach at Exhibit 18. Based on the official database of medication information that H223 has supplied in the e-mail Matthews is currently on the maximum dose of the following medications: Lurasidone, anti-psychotic; Epilim Chrono, mood stabiliser; Priadel, mood stabiliser; Melatonin, hormone, on higher than recommended dose. 11:57

He was also previously on the maximum dose of Haloperidol which is an anti-psychotic. This was reduced at my family's request and consultant agreement. 11:57

Matthew is also on procyclidine, an anticholinergenic to counteract the side effects of all the anti-psychotic medications. 11:58

I believe that it has only been since this year, with the assistance of H223, that there has been any transparency over Matthew's medication and any

willingness to make changes in response to concerns my family have expressed. H223 has also been willing to acknowledge on several occasions that Matthew is on a significant amount of medication and he is trying to reduce this to a therapeutic level, but this has only happened since Matthew has started his transition into the community. I believe this has only been possible because H223 feels more able to do this outside of MAH. 11:58

In my view, Matthew's medication regime in MAH was chemical abuse and has significantly contributed to his deterioration." 11:58

Then at 58 you say: 11:59

"There were few very caring, compassionate and supportive staff. I recall H629, an auxiliary nurse who worked the evening shifts, and H593, a behavioural nurse. Matthew spoke highly of them and his face would light up when he saw them. He would always have asked is H629 coming in? 11:59

I remember my mother telephoning me extremely upset after leaving Matthew back to MAH after a lovely home visit. My mother informed me that Matthew asked Staff Nurse H459: "Is H629 in" and her response was: "Don't know". Matthew then repeated the question and H459's response was, whilst making a gesture of opening her jacket: "She's not in my pocket." My mother was so 11:59

distressed she said that H495 responded to Matthew with a smug grin on her face. She also told me that at this point Matthew went pale with extreme anxiety. My mother then asked H459: "Is H629 working tonight?" Matthew had his back to H459 as H459 responded with a wink and nod, indicating H629 was in. In response to this, my mother told me she reassured Matthew instantly by saying: "Matthew, it's okay, your night is made, H629 is in." 12:00

This is just one example I can recollect of how staff can be casually cruel, disrespecting Matthew as a human being, teasing him and disregarding his learning disability. This type of attitude and treatment could have a significant negative impact on Matthew with regards to his behaviour. Looking back now I regard this as a form of mental torture towards Matthew and if that was how staff thought they could speak and treat patients in front of their relatives, I wondered how they were being spoken to in their absence." 12:00 12:01

Then if you turn to paragraph 65, you say:

"It has only been over the past year that my family have been made aware of safeguarding issues and the fact that policies were in place to investigate these. Even so, I believe they are not being followed through in a timely manner and my family have not been provided with regular updates. In my view, a speedy 12:01

investigation is essential if there are to be effective changes.

I understand several safeguarding incidents involving Matthew that we raised were not investigated by MAH as safeguarding and, as far as my family are concerned, were not properly explained. An example of this is when we have on several occasions questioned bruising found on Matthew and queried as to where and how these bruises had originated. We were told by MAH that Matthew was clumsy and had bumped into a wall or doors and there would have been no further investigation or explanation. 12:01 12:01

Another example was when Matthew presented with faeces under his nails. Again this occurred on multiple occasions. When this was raised by family to MAH staff they would become defensive and their attitude would have changed towards us. There was never an investigation into how this was allowed to happen. My mother raised concerns to MAH staff that this lack of personal hygiene may be a factor as to why there was out breaks of Norovirus on frequent occasions in MAH which Matthew was subjected to. I have given an example of a recent safeguarding issue which was highlighted to me by H626 from the safeguarding team in MAH. A member of the Inreach team from Matthew's new had reported that two members of the MAH staff pulled the mattress from below Matthew whilst he was still in bed. One of 12:02 12:02 12:02

the MAH staff said to the Inreach staff: "This is how we do it", which would indicate that this was the normal protocol for certain staff. I understand one member of staff went off on sick when this was raised with them.

In relation to Matthew's difficulty in getting out of bed, this could be caused by several factors such as the high dosage of sedative medications he is on and/or his low mood due to lack of stimulation and the environment he was living in.

I should say there were numerous occasions when we saw things in relation to Matthew that we considered to be concerning or troubling. We did not always raise these issues because there was a worry about the impact of doing so on Matthew whilst he was under their care. Matthew's resettlement placement was identified with Inspire Mallusk in June 2020. Following significant delays with ongoing staff recruitment and no confirmed date for his resettlement, my family issued judicial review proceedings on behalf of Matthew against the Northern Health and Social Care Trust.

As a result of the judicial review proceedings Matthew's resettlement to Mallusk was due to start on 31st October 2022 and expected to take six to 12 weeks."

And you then, Jennifer, at paragraphs 72 to 78, explain a little bit more about the resettlement process and particularly your interactions with the Northern Trust in respect of that. And I am going to pick up the reading there, the Panel has all that, I am not going to read it all aloud but I'm going to pick up the reading at paragraph 79 where you say: 12:04

"Matthew only began his transition in May 2023 and by the 1st of June 2023 he was offered an opportunity to stay overnight in Mallusk. Since then, Matthew has remained at Mallusk and it has been a rollercoaster of a journey for both my family and most importantly Matthew. I believe his transition has been extremely rushed, in my view due to financial factors and the fact MAH is now set to close. We were promised that the transition would be at Matthew's pace which it most certainly has not been. I believe a patient-paced transition is essential for successful placement. We as family cannot see another failed placement for Matthew. 12:04 12:05

MAH have had a big say in Matthew's routine and passing that information on to Inspire. I do not agree that the routine implemented in MAH was ever in Matthew's best interests. I have been told that MAH did not like to do much with Matthew in the evening as his bedtime routine started after dinner at about 5.30 p.m.. I feel this is ridiculous and deprived Matthew of any 12:05

evening activity or enjoyment. This is something we are insisting is changing in his new home but we are yet to see much change.

During July 2023, Matthew was reduced off Haloperidol by 0.5 milligrams per week. In the middle of August 2023, after about two weeks of being off Haloperidol, Matthew was presenting with more challenging behaviours and appeared to be getting more PRN administration. I believe these behaviours may have been influenced by the sudden departure of a key member of the Inspire team, the activity co-ordinator who worked very well with Matthew as he had a great bond her. The behavioural changes may have also been the effects of drug withdrawal. 12:05 12:06 12:06

As staff within Inspire are not medically trained, I do not believe they have the expertise to deal with medication withdrawal and additional MAH nursing staff should have been supporting Matthew during the reduction of Haloperidol and the withdrawal side effects he was likely to experience. I do not believe Inspire requested additional staff to support this. 12:06

Following an unsettled week for Matthew, an emergency meeting was called on 18th August 2023 by H647 in which the time had to be scheduled around Matthew's Consultant, H223. Family availability was not considered. The meeting included members of the via 12:06

settlement team, Inspire Management, both Belfast Trust and Northern Trust behavioural staff, Matthew's Consultant, our family liaison social worker and my family. During this meeting, the behavioural teams from each the Northern Trust and the Belfast Trust were in conflict over whose role it was to provide behavioural support for Matthew. I feel that the actions from this meeting had already been decided and family concerns were not going to be considered. My family raised once again that we felt Matthew's resettlement had been rushed and that he was not being provided with the support from MAH that he should be, i.e. behavioural and daycare support was nonexistent. Also, Matthew was not being exclusively supported by nursing staff during his medication changes. 12:07

The actions from the meeting were that MAH were to provide additional supporting staff over the upcoming weekend which they were unsure at that stage they could do and that Matthew would commence a new anti-psychotic Olanzapin at 2.5mg per day. My family felt helpless and that these so-called professionals were not giving Matthew a chance to potentially get through this unsettled period. They were wanting him to go on additional medication near enough immediately. 12:08

Following this meeting, contact was made with our MLA representative, Gerry Kelly, who telephoned H234 and during this conversation she said that the behavioural

specialist was on her way to see Matthew. The behavioural nurse did not turn up so by that stage and to date, there has been no behavioural support input provided to Matthew from the Northern Trust or Belfast Trust since he moved to Mallusk. 12:08

Following this, Olanzapine was increased to 5mg per day as the lower dose was having no improvement effects as reported by Inspire and MAH staff. Since this, Matthew has had to attend A&E on two occasions; 27th and 29th August 2023 with seizure-like activity. The outcome of his traumatic A&E admissions was that this behaviour was most likely medication-related and that Olanzapine was to be discontinued. I have included the relevant e-mail updates from Matthew's Consultant, H223 at Exhibit 23. 12:08 12:09

Although Matthew is currently not within the MAH environment, he is very obviously experiencing flashbacks of his alleged abuse in MAH and this is making his behaviour extremely challenging at times. I am unsure whether this has been considered by MAH, the Resettlement Team or Inspire. My family have requested for Psychology input for Matthew and to support the staff that work with him to help them understand better what he has been through and how to deal with him when he brings up traumatic memories of the past. We have been informed this will provided by the Northern Trust when he is discharged from MAH but 12:09 12:09

in the meantime we will continue to did if this can be provided by the Belfast Trust.

Matthew has been under the care and treatment of the psychiatric hospital for a period of 16 years and during that time, he has significantly regressed. By way of example, Matthew is now using flash cards for communication whereas previously it would have been possible to explain to him what was going to happen and he would have understood this well. Also, Matthew is now largely double incontinent, his whole presentation is different. Matthew is unable to fully communicate the impact on him of his MAH experience. I am concerned that without specialist assistance, no-one will ever know the exact the effects MAH has had on him or what should be done now to best help him. My family would like Matthew to be independently assessed as we have no confidence in the diagnosis and treatment he received in MAH. 12:09 12:10 12:10 12:10

My family have been left heartbroken because Matthew was put into MAH with the belief that he would helped, only to find that in fact he has been significantly hurt and damaged by his experience. It is impossible now to give him back the life he would have had if he was properly looked after." 12:10

Jennifer, that ends the substance of your statement. You then go on to give the declaration of truth and

list and provide the number of exhibits that you have referred to in the statement. So having heard me read all of that aloud today, are you content that it is accurate, first of all?

A. Yes. 12:11

6 Q. And do you wish to adopt it as your evidence to the Inquiry?

A. Yes.

7 Q. Are you comfortable continuing straight to questioning now, you don't need a break? 12:11

A. Yep.

8 Q. Okay. If you do need a break any time you can let the Chair know.

A. Okay.

9 Q. So the first thing I want to ask you about, Jennifer, is the pod, which is the first thing that you dealt with in your statement, and you described how Matthew was moved from the main ward in Cranfield 1 to the pod which was in Cranfield 2, isn't that right? 12:11

A. Yep. 12:12

10 Q. And that move was in January 2020?

A. Yes.

11 Q. What were you told at that time as family about why Matthew was moved to the pod?

A. I think it was actually subsequent to that we were told that there had been, we have got more details, what there had been safeguarding issues and we were actually given mixed messages. At one point it was safeguarding issues against Matthew from other patients and then 12:12

we've also since heard what it was actually Matthew, there was patient-to-patient safeguarding issues from Matthew to other patients. So to be honest, we haven't really got to the root of why he was moved.

12 Q. What were you told about what the pod was like at that time and what facilities it would have for Matthew? 12:12

A. I don't really think we were actually told much. It would have been my parents that were in a meeting, multidisciplinary meeting, and like I said, they were painting a pretty picture that it was going to be an area that Matthew could move freely to and from and that it was just off the ward, he have access still to the main ward and it would really just be used to allow him to go and calm down and regulate and then he would be able to come back into the main ward again where he had access to the garden and other staff and other patients, but this wasn't the case. 12:13 12:13

13 Q. How did you know that that wasn't the case?

A. We only became aware of that when we got in to see the pod in January 2022. I suppose all over from the Covid restrictions, we weren't even able to visit him so we were never aware that he wasn't being allowed into the main ward or what it actually looked like. 12:13

14 Q. So it was January 2022 when your family first saw the pod and you have provided some photographs of the pod, which I think we can bring up on screen now for IT. These are photos 1 to 6 and, Panel, these photos appear at 24 to 29 of the Exhibits. If we can just bring those photos up and scroll through them, please. 12:14

So if you look at your screen, Jennifer, you will see these first one is a photo of Matthew in the pod?

A. Yeah.

15 Q. When was that taken, roughly even?

A. In 2022, this was after.... 12:14

16 Q. Okay.

A. It would have been probably mid 2022 because we had to fight for him to get a table and chairs.

17 Q. Okay. So this is in the table and chairs, you mentioned there were three rooms in the pod. Which 12:15 room is this in?

A. This would have been considered a dining room.

18 Q. Okay. And whenever you first saw the pod, was that table and chairs in there then?

A. No. 12:15

19 Q. So when did it go in, do you know?

A. I'm unsure.

20 Q. But after January 2022?

A. Yes.

21 Q. Okay. And go to the next photo then? 12:15

CHAIRPERSON: Sorry, what was in the pod before they put that furniture in? What was in that room, can you remember?

A. No, I can't remember. At the start of 2022 I was unable to visit, it was only my Mummy and Daddy were 12:15 able to visit so I would have to pass that question over to my Mummy, if possible.

22 Q. MS. KILEY: Okay. There's another photo coming up, so this is the same room, we can see the table and chair?

A. Yeah.

23 Q. And a rocking chair then?

A. And they had attempted to decorate it by putting that on the wall.

24 Q. Yeah. And if we can go to the next photo then please. These are large files so IT have alerted me to the fact that it can take a little while to move from photo to photo. So what is this a photo of? 12:16

A. It just shows how grubby it looked.

25 Q. What is that on the floor? 12:16

A. I think it might have been where there was possibly an old wardrobe or bed that had been taken out for Matthew to then use that as another room that they considered a dining room.

26 Q. So this is the dining room still that we were just looking at? 12:16

A. Yes, this is still the dining room. So they never attempted to wipe the floor. It was just grubby, horrible.

27 Q. And the next photo, please. So is this now Matthew's bedroom? 12:17

A. No, that's the living room. So they left the -- that would have been what a bedroom looked like, that was one side where they had a small TV, so that would have been a bedroom TV. Matthew was never given a big TV that the other patients would have been able to access, he was just left with what would have been a previous bedroom. That was the size of the TV that he had to view on a daily basis, behind a perspex panel, and 12:17

there was a window on the other side and if the sun was shining in, there is no way he would have been able to see that TV. And that also would have been the desk space that he would have had to eat his meals on before they got him a table and chairs. 12:18

28 Q. Yes. So you described that in your statement, so that's where he would have had his dinner before?

A. Only his bedroom, not actually there, but that's the same set-up.

29 Q. The same style, okay. And was that TV then changed? 12:18
You described your concerns about that.

A. It took us literally until -- I think he got a bigger TV put in maybe February/March '23, just before then he got moved into the main ward. But what they were trying to say that they needed to order parts in to put 12:18
it behind a perspex screen and in the end they just ended up moving the TV in and just letting it sit on the shelf, and they didn't put it behind a cover.

30 Q. CHAIRPERSON: And can I just ask, could Matthew change the channel if he wanted to? 12:19

A. I don't know.

31 Q. CHAIRPERSON: Just looking at that.

A. Well, he couldn't have done it touching the TV but I never seen a remote when I was there.

CHAIRPERSON: Okay. 12:19

32 Q. MS. KILEY: Okay, the next photo then please. What's this we're looking at now?

A. This is the sloping chair that he had in that living area before he got a sofa. That would have been all

there would have been. And then you can also see marks on the walls. There was no attempt of making the place look presentable before Matthew was moved into it.

33 Q. So the sofa, is that the brown thing we can see in the corner? 12:20

A. Yeah.

34 Q. That wasn't always there, is that what you're saying?

A. No.

35 Q. Before that, there was the sloping chair, just?

A. Yes. 12:20

36 Q. And was there anything else in that room?

A. I can't recollect.

37 Q. Okay. And the next photo, which is the last one, what are we looking at in that photo?

A. This is the hallway. The door that you can see open is into the dining room, then there was his bedroom and then where the photo is being taken from would have been a door into the living room, and Matthew is looking through into the main ward here. Although that looks like a big window panel he's looking through, there's like a sticker around it that you can't see there and it's actually only a match-sized box that he is peeping through to look into the main ward. 12:20 12:21

38 Q. On the right-hand side of that photo, we see a closed door there. What's that? 12:21

A. Unsure. That was never opened.

39 Q. It wasn't something that Matthew used?

A. No.

40 Q. CHAIRPERSON: Sorry to keep interrupting, just so that

we understand, his access to seeing what was happening in the outside world, as it were, would be through that little part left open in that window into the ward?

A. Yes.

41 Q. CHAIRPERSON: And an outside window, was there an outside window as well? 12:21

A. On the other side where the photo is being taken from, there was the door into the outside and he couldn't see through it, I think the glass was completely -- it would have been a long Panel of glass down it, from what I can recollect, and it would have been completely covered but some light would have came through it, but not a lot. And that's another thing when you opened that door previously, it was out into the Muckamore grounds, Matthew wouldn't have been allowed out there and we had to fight for him to get -- it was like a grass area and we had asked for a fence to be put round it so he could access his own garden because they weren't letting him into the main ward to access that garden. And it took -- we had asked for that I think in May '22 and it took them until about October/November '22 to fence it off because they didn't just fence it off, they then decided to pave it, they ripped up all the grass and paved it and it just literally looked like a prison courtyard, it was horrendous. So that would have been what Matthew would have then got out in, but by that stage it was the winter. 12:22 12:22 12:22 12:22

42 Q. CHAIRPERSON: And he was in this pod, did you say, for

three years?

A. Yeah, over three years.

43 Q. MS. KILEY: During that three year period, Jennifer, did Matthew get any therapies whenever he was in the pod? 12:23

A. Again, over Covid we were told due to Covid restrictions, there was very little they could do with him but, really, Muckamore were in their own private bubble, there should have been still daycare support which he wasn't getting and we had to fight for that 12:23 once we became aware of what he had been living in and that he wasn't getting access to the main ward and when we asked, you know, can he get daycare, can he get out and about, we had to fight for it and then it was only about March 23, again I feel it was from when we had 12:23 MLA involvement, that they started putting all this effort into Matthew but by that stage, he was then going through the resettlement process so I feel they were just doing it to keep us happy until he got out the door. 12:24

44 Q. You mentioned there daycare. So are you saying that whenever he moved to the pod, he wasn't leaving the pod to access daycare?

A. No, there was days he was just locked in there all day/every day and weekends as well. We found even when 12:24 there was daycare when we had fought to get it in place again, daycare very rarely happened over the weekend so Matthew could have been in there from a Friday until a Monday and it was only my Mummy and Daddy or me going

up at the weekends would have broken up his weekend.

45 Q. Were staff constantly with him in the pod?

A. There was always one staff member but again, you know with the safeguarding issues that we have had to deal with, with him being there, I just had no trust in any staff, well very little staff, and the fact he had only had the CCTV recording in that hallway area, we just didn't know what was going on in the other rooms. 12:25

46 Q. And you said in your statement that you continually raised your concerns about the pod once your family found out what it was like, and that you pleaded for Matthew to be moved out of the pod? 12:25

A. Yep.

47 Q. Did you have a named person at Muckamore who you could bring your concerns like that to? 12:25

A. No. The first port of call usually would have been the Ward Manager but like I said, they were chopping and changing all the time and it was so hard to keep up with who was actually in charge, and then I would have went as high as the Co-Director and then when that failed I went even higher. 12:26

48 Q. And you have provided the Inquiry with some of your e-mails or examples of the contact that you made in your exhibits, I am not going to take you through all of them, but one of the things that you say in your statement is that you were asking for Matthew to be moving from the pod from February 2022 when you found out that that's where he was and that's what it was like but he wasn't moved out of the pod then until May 12:26

'23, is that right?

A. March '23.

49 Q. March '23. So were you given an explanation as to why it took so long to move him out?

A. During the meetings we would have had, they would have said; 'Oh, we could attempt, you know, we don't think it's a good idea to move him completely because he has been so used to being in the pod, we'll do it gradually, we will slowly break him in, we'll take him down for maybe the morning where it's a bit quieter, and then he can go from there to daycare.' This is when daycare was up and running again. But they put these plans in place and never followed through, and we were going from one meeting to the next, and I was asking for updates on how it was progressing and they would have used the excuse that they were understaffed or the ward was unsettled or Matthew was unsettled, and we just never seen any progress. And then all of a sudden March '23, they just moved him straight in, there was no transition. So to me, they were just trying to put it off for as long as possible because they thought he was out of sight/out of mind in the pod. 12:26 12:27 12:27 12:27

50 Q. When you say there was no transition, was there a re-introduction process before he went in? 12:28

A. No.

51 Q. Okay.

A. This is what they had tried to say they would do but they never did. And then, when we had the meeting in

March '23 with our MLA present it was on a Friday, I think, and by that Monday Matthew was just moved into the main ward and he was put on -- so he went from being on a one-to-one staffing to I think a two-to-one when he moved into the ward until he resettled back in. 12:28

52 Q. How did he manage moving back into the main ward?

A. We were told that there was incidents and that that's why they increased staffing numbers on him, but that was to be expected. He had been locked away for three years, had very little contact to the outside world 12:28 because of Covid and then he didn't have the support that he should have been getting through daycare and other supports that the hospital should have been providing, so obviously he was going to go in and be a bit elevated when he seen other people and patients and 12:29 staff, he was always just so used to being with one staff member. You know, some of the staff would have been really caring with him but others, they wouldn't have had much communication with him and based on what we witnessed, they didn't give him the care and support 12:29 that he needed in terms of his physical support.

53 Q. You refer to engaging with a number of people at Muckamore about your concerns about the pod, you've set all that out in your statement, and one of the things that you say is that you did eventually make a formal 12:29 complaint to the Belfast Trust about Matthew's living conditions and you provided that complaint letter that you submitted in your exhibits. For the Panel's reference, it is at page 52, I don't think we need to

turn it up, but what you have provided is your letter to the Trust making the complaint and I wanted to check with you have you received a formal written response from the Trust to that complaint letter?

A. To be honest, I can't recollect if I did or not because there was much going on trying to actually fight to get him out of the pod and then we were also trying to get his re settlement process initiated to get him out of Muckamore completely. So I can't remember whether I got an e-mail follow-up from it or a letter, I honestly don't know. 12:30 12:30

54 Q. Okay. The next topic that I want to ask you about is Matthew's medication. And one of the things that you pick up in your statement is that Matthew has an allergic to benzodiazepines? 12:30

A. Yep.

55 Q. You describe that in detail. When was that allergy discovered?

A. It was -- my Mummy would have been told.

56 Q. Was it when he was in Muckamore? 12:31

A. Yes.

57 Q. It was when he was in Muckamore?

A. Yeah.

58 Q. And what type of reaction would he typically have?

A. I think he was restless, he just couldn't -- his behaviour wasn't good when he was on it so the doctor then said he was allergic with it, he would have completely went off as they considered baseline so it wasn't having any beneficial effect on him and that was 12:31

any of the benzodiazapine drugs that he would have went on had that effect on him so that's why -- I'm just looking at which doctor. H40 had told my Mummy that he was allergic to benzodiazepines but then he subsequently put him back on to diazepam in 2018 and that is when his behaviour then went off again and he was then just put on other medications because they were putting it down to Matthew's behaviour but, really, it was his reaction to a drug that he shouldn't have been on again. 12:32

59 Q. When did you ...(interjection)

DR. MAXWELL: Can I clarify, did the doctor say an allergy or reaction? Because they are two different concepts.

A. I can't answer that. 12:33

60 Q. DR. MAXWELL: You didn't get anything in writing? You haven't seen anything?

A. No, there's nothing in writing, but I think it is in his written medical notes.

61 Q. DR. MAXWELL: You have seen it in his medical notes? 12:33

A. I haven't seen it in his medical notes but I'm almost sure his current consultant has told us that it's in the medical notes that he is allergic to.

DR. MAXWELL: Thank you.

MS. KILEY: There are some care plans not exhibited to this witness's statement but exhibit to Mary's statement and they are the last exhibit to her statement and there is a note there about, I think it says allergy, I'll check the language, but there is a 12:33

reference there. Just one of the things that you refer to in your statement, we are talking about this issue, is a medicine review that happened and if we could bring that up please, page 87 of the exhibits.

12:33

So we can see there is a two-page document, the first page is on your screen there and you see that the first sentence refers to a review at end of 2017 and 2018 to see if any factors, particularly in relation to his medical, that contributed to a more positive clinical presentation can be identified. Do you know what brought about that review why it took place at that time?

12:34

A. So we, as a family, had asked the doctor to look back to that time period. His current Consultant, H223, we had asked him could he review that period and tell us what medications he was on. So that's why.

12:34

62 Q. So when did he conduct the review?

A. That was July '23.

63 Q. Okay, so the review was conducted in July '23 but it was a look-back at this time?

12:34

A. Yes.

64 Q. And that was by a different doctor, isn't that right?

A. The review?

65 Q. Yes.

12:35

A. Yes, the review is by his current consultant so he was looking back at his medical notes.

66 Q. Okay. And we can see there, if you scroll down to the date, the 25th of January '18, if you just keep

scrolling down and pause there, you can see there under the 25th January '18, there is reference to diazepam, 2mgs, and then if you keep scrolling down, we can see the 26th of July 2018, there is another reference "diazepam increased" and if we scroll to the next page please, and pause there, on 24th October 2018 there is a reference to diazepam being stopped. So at that time, so in and around the 2018 period, was your family aware that Matthew had been prescribed diazepam? 12:35

A. No, we were unaware of any of these medication changes. 12:36

67 Q. Since now becoming aware of it, did you receive an explanation of why that occurred?

A. No, his current consultant can't, I suppose, give reason for why another consultant has put Matthew on this. 12:36

68 Q. Okay. In your statement, whenever you're discussing the medication, you say that in your view, Matthew's medication regime was chemical abuse and I just wanted to ask you what you mean by that phrase?

A. The amount of medication he has been on over the years is just ridiculous. His current consultant has said to us on multiple occasions that Matthew is on a lot of medication and that he wants to try and get him off as much as he possibly can, and when I just look at that review over a period of a year and see the medications he has been put on and taken off and I just find, put him on one and they have him straight up to the maximum dose within a short period of time, and they have never given him a chance to adjust to maybe a lower more 12:36 12:36

therapeutic dose to see how he would perform on that, they just put him up to the top dose, have him on that and then counteract the side effects of that with another drug, and that's what I mean by chemical abuse, because they are just putting one medication into counteract another side-effect and he is on the top dose of everything.

69 Q. And during Matthew's time period in Muckamore, did your family have regular contact with the prescribing clinicians about what medication Matthew was on? 12:37

A. My parents would have attended MDT meetings I think every six to eight weeks. I wouldn't have attended them with them in the earlier days and from what I am aware, I think some consultants were better than others at making them aware of what medication Matthew was on, 12:38 but I don't think they knew to the extent of what he was on. It might have been, like, the one main drug that he would have been on and not all the others that would have been given to him to counteract the side effects. 12:38

70 Q. Okay. One of the other things you talk about in your statement is what you describe as the overuse of PRN. Why do you feel that it was overused in Matthew's case?

A. When he was in the pod, he very rarely got PRN because he was with one member of staff and like I said, we had 12:38 fought for him to get out to be moved back into the main ward and I feel when he was moved into the main ward, the use of PRN was being given basically every day and I felt that they were trying to make a point

that; 'We told you Matthew couldn't cope in this environment, he's too elevated, we need to be giving him this medication every day to calm him down', and really it was just sedating him and turning him into -- they were just trying to sedate him and have him sit in the corner doing nothing and they didn't need to do that in the pod because he was in such a small area and when we would have asked, you know, what was done before you gave him PRN, because we were told by his Consultant that it should be a last resort, they never had, they could never support that they had tried other strategies before giving it to him. 12:39 12:39

71 Q. In terms of putting a time period then on that concern, you're referring to the time period when Matthew moved out of the pod and back into the general ward. So is that the only time you had a concern about PRN? 12:40

A. No, it would have been previously as well. There was times in the pod that he was being given PRN as well and we questioned that, and again they couldn't give us good reasoning for why he was given it, they might have just said; 'Oh, he was off baseline', but there was never; 'We tried X, Y and Z before we gave it to him.' It is only his recent, his current Consultant had made us aware that other strategies should be used, this calm card he referred to it as, and we had never heard any of those approaches being used before PRN was given. 12:40 12:40

72 Q. Did your family ever get an opportunity to share with staff at Muckamore the type of strategies that might

help Matthew?

A. We would have raised in meetings how we felt Matthew should have been approached and, you know, if staff are nice to Matthew and staff speak to Matthew in a respectful manner, Matthew would appreciate that and he responds better to that. Communication is so key with him and it just felt we were talking to the wall you know. You know, it never felt -- like I said, they never made notes at meetings, there was actions discussed and then nothing ever came of it. I always felt I had to come out of meetings and send a follow-up e-mail to, you know, basically have something in writing that what we had discussed in the meeting, because I knew I was never going to get it from them. I can't really remember where I was going with that. 12:41

73 Q. That's okay. I know you have a photo that you want the Panel to see of how Matthew presented whenever he was on PRN, so this is at page 86 of the exhibits. I think ITU, you have it as 101?

CHAIRPERSON: I think it's 84? 12:42

MS. KILEY: 86 in your exhibits but IT are working with slightly different numbering because of the size of the files.

CHAIRPERSON: Okay.

74 Q. MS. KILEY: Is this the photograph that you wanted the Panel to see? 12:42

A. Yes.

75 Q. What do you want them to understand about this photograph?

A. This is not Matthew, this is just horrendous. My mummy had taken this photo and she sent it to me when she got back, she was extremely upset.

76 Q. When was it taken, Jennifer?

A. I would say sometime in 2023, I can't recollect when, but this is not just a one-off, this is just not a one off, we would have seen him like this when he was on PRN and even when he wasn't on medication, this is the type of way he would have been presented in terms of his clothing, his hair, just looked untidy, not clean. But his face there, you can just see how sad he looks and looking at that, I just feel numb, it just isn't my brother. 12:43 12:43

77 Q. I know you also have photographs that you want to compare that with, so now might be a good time to bring those up. These are at pages 82 and 83 of the exhibits, 9 and 11 for IT. 12:44

A. Yeah.

78 Q. When was this one taken, Jennifer?

A. This, I think, was maybe like Spring '18 and that's whenever we seen -- he was doing really well, this was before he was started on Haloperidol and you can see that's the build Matthew is before he gets medication, he was always a slim build fella, always liked to look clean and tidy and smell nice and he's happy there. 12:44 12:45

79 Q. Was that taken at home, that photo?

A. Yeah, that's actually in my house, yeah.

80 Q. Okay. And the next photo then please?

A. So he would have been able to come home and visit at

that stage, my Mummy and Daddy would have called in with him there at my house, there would have been no staff or anything with him, but now that just wouldn't be possible.

81 Q. Okay. You can see...(interjection) 12:45

A. This is more recent. I think this has been taken from he's moved out of Muckamore. He looks happy there but you can see the amount of weight he has on him because of the medication he's on.

82 Q. CHAIRPERSON: That's at Hazelbank, isn't it? 12:46

A. Yeah.

83 Q. MS. KILEY: And those are the pictures that show the comparison of Matthew in different times.

A. Yep.

84 Q. You've explained a little bit in your statement about how the things that Matthew used to be able to do that he can't do. Can you say anything more to the Panel about how Matthew changed since being in Muckamore and the type of things that he used to be able to do that he now can't do? 12:46

A. Basically everything, you know, something a simple as just sitting down with his family and eating his dinner, now, like, we feel like when Matthew gets food put in front of him, he, like, rushes to eat it and looking back now, is it because it was ripped away from him, you know, when he was -- and he feels now he has to eat it as quickly as possible before it's taken from him. Matthew could have sat with us as family and he would have come even in his early days in Muckamore and 12:46

had dinner with us every Sunday and we would have sat as a family and ate together, being able to go out walks together, like, again in the earlier days my mummy would have went up to visit, and I would then have picked her up after work and we could have walked Matthew around the grounds of Muckamore with no issues whatsoever. Like, looking to now in the later years what he has turned into, you know, two staff had to come out with us because they were afraid of him running away or running towards people and it's just not him. 12:47 12:47

85 Q. Is that still the case now if you go out with Matthew, two staff need to go with him?

A. Even from when he's been resettled, he hasn't had a home visit yet, he hasn't been taken out. His behaviour is just a bit too unpredictable at the minute still and that could be, I suppose, to do with a complete change of environment, his medication being changed, a multitude of reasons, different staff, but he is just too unpredictable to be able to do that. He was never that nature, didn't have that unpredictable nature. You could always predict him and, like, talk to him to calm him down and I just feel like that's been stripped from him, it was just; 'Throw medication into him and that will calm him down', and I feel like that's just destroyed him and we want him to be reduced off as much as possible now because in the long-term, ,what effect is that going to have on his physical health, not just his mental health in terms of his 12:48 12:48 12:48

liver and kidneys. I don't want to be sitting in years to come with him having issues there. Yes, simple things even his own personal hygiene, you know, he could have went into the toilet and used the toilet himself and washed his hands and whatever. Like I said, they just pumped incontinence pads on him and left him to it.

86 Q. Okay. Jennifer, those are all the questions that I have for you about this part of the evidence. The Panel may have some? 12:49

CHAIRPERSON: I think Dr. Maxwell has some.

P34'S SISTER WAS THEN QUESTIONED BY THE PANEL AS FOLLOWS:

12:49

87 Q. DR. MAXWELL: Yes, I just want to go back to the PRN. In Exhibit 9, which is on 173 to 175, which is an MDT meeting on 27th April this year, there is a discussion that you had raised some concerns about whether there was a pattern about certain staff giving more PRN? 12:49

A. Yes.

88 Q. DR. MAXWELL: And although they said this wasn't apparent, they did actually say towards the end of the paragraph headed: "Use of PRN medication and calm card: 12:50

"The Use of PRN medication per patient is tracked each week."

Did you ever get to see the document? Do you know what they were tracking?

A. No. I had asked this on a few occasions, I had said, do you know, we feel that depending on what staff are working with Matthew, what management are in charge of, you know, giving out the PRN was depending had on how much he had got and would it be possible for them to track it? And I said: "I don't want to know names, even if you can just code them, and just see if you are seeing a pattern". And they didn't really agree to this and then all of a sudden at one of these meetings they said; 'Oh, we do do that and we track it but we don't see any trend', but they were never willing to share any of that information. 12:50 12:50

89 Q. DR. MAXWELL: They didn't tell you exactly what they were tracking? 12:51

A. No.

DR. MAXWELL: Okay, thank you.

CHAIRPERSON: I have asked my questions as we've gone along and Professor Murphy has no questions. But we do now need to move into restricted session. I am aware that witness has been going for quite a while. What I am tempted to do is take quite a short lunch and then reconvene with the witness afterwards. Is that going to cause problems for the next witness though? 12:51 12:51

INQUIRY SECRETARY: I'll just check.

CHAIRPERSON: Yes, if the witnesses would rather carry on, then we can carry on.

MS. KILEY: Chair, while the secretary is doing that,

I will just update in response to Dr. Maxwell's earlier question about whether the benzodiazepines were noted as an allergy or a reaction, I referred you to the care plans and the page number is 63 in respect of Mary's exhibits. So that's where you find it. It states -- 12:52
this is a Northern Trust care plan. It says "allergic to" and benzodiazepines are listed.
DR. MAXWELL: I think they wouldn't have had that first hand. Whether we had any evidence of it from the medical records from the Belfast Care Trust and maybe 12:52
that's something we will pursue separately.
CHAIRPERSON: Tell me where we are with timing?
MS. KILEY: I am being told, Chair, both witnesses would rather continue, if that's suitable to the Chair and to the Panel. 12:52
CHAIRPERSON: Okay, no, of course, we can keep going as long as you want to. Does that work for you?
A. Yes, I just kind of want to get it done.
CHAIRPERSON: I understand, all right, as long as you can still concentrate and give us your best, all right. 12:52
A. Yes.
90 Q. MS. KILEY: Perhaps the thing do then is to start with you, Jennifer, since you remain in the Chair, so if you give me a moment, we will just turn up the relevant paragraphs. 12:53
CHAIRPERSON: 57, I think.

THE HEARING THEN WENT INTO CLOSED SESSION

THE HEARING THEN WENT INTO OPEN SESSION

CHAIRPERSON: Now we're quite tight on timing today, two witnesses, three witnesses actually this afternoon.

MS. KILEY: Three this afternoon, one of which is just to be read. So P118's mother's statement is to be read and P118's sister will give live evidence and then P8's mother is schedule for 3:30. 13:07

CHAIRPERSON: Okay. Well, it might be a slightly later end, I suspect, than that. I do think everybody needs 45 minutes, though, at least. Can I ask, please, that we start promptly at five to two. 13:08

MS. KILEY: And I should flag up that there may be an application for a Restriction Order in respect of P118's mother. I will liaise with PSNI about that and provide clarification about that at the outset. 13:08

CHAIRPERSON: Okay. Five to two. Thank you very much.

LUNCH ADJOURNMENT.

THE HEARING RESUMED AS FOLLOWS AFTER THE LUNCHEON ADJOURNMENT:

CHAIRPERSON: Are we using first names or.

MS. BRIGGS: We are using ciphers, Chair. 14:12

CHAIRPERSON: Ciphers OR first names?

MS. BRIGGS: Just ciphers.

CHAIRPERSON: Okay. Right, good afternoon. Oddly, I am going to have to call you "P118's mother" and you'll just have to get used to that, I am afraid. You 14:13 understand the reasons for that?

A. Yes, I do indeed.

CHAIRPERSON: You are now going to be sworn in.

P118'S MOTHER HAVING BEEN SWORN WAS EXAMINED BY MS. 14:13 BRIGGS AS FOLLOWS:

91 Q. MS. BRIGGS: Okay, P118's mother, you can hear me okay?

A. Yes.

92 Q. You can hear me okay? 14:13

A. Yes. Thank you.

93 Q. All right. I have explained to you what I am going to be doing this afternoon, which is reading the statement that you have provided to the Inquiry out loud for everyone to hear, okay. I have explained to you that 14:14 there may have been an application for a part of the evidence to be restricted, okay?

A. Yes.

94 Q. That has been granted okay, so there are two paragraphs

you'll notice, that I won't read at this stage okay. Those will be read at a later session later on this afternoon, okay, when I'm done reading the rest of the statement. Are you content that I start to read then at this stage? 14:14

95 Q. CHAIRPERSON: You have got the statement in front of you, if you want to follow it.

A. Yeah.

MS. BRIGGS: Okay. So picking up at paragraph 1. 14:14

"My connection with MAH is that my son, P118, was a patient in MAH. I attached a photograph of my son at Exhibit 1. The relevant time period that I can speak about is four separate periods between approximately 1983 to 2017. 14:14

My son, P118, was born in 1973. P118 is aged 49 years old. Prior to P118 being admitted to MAH, he lived at home in the community with our family, including his sister and brother. P118 was fit and healthy and 14:15 enjoyed cycling and could cycle eight to 10 miles in a day.

P118 was born with severe learning difficulties accompanied with autistic symptoms. P118 did not 14:15 receive a formal diagnosis that I'm aware of. It may have been during P118's third admission that he was formally diagnosed or labelled. P118 has required constant care and attention from birth. P118 also

suffers with high levels of anxiety and stress. P118 is verbal and has good communication skills and can understand right from wrong. P118 can identify if he is being mistreated.

14:15

P118's first admission to MAH was in or around 1983 or 1984. He was admitted to Ward M7, an admissions ward, for around three to four months for assessment. P118 had been disruptive at school, home and at his activity club. The aim was to lower P118's anxiety, which has worsened since leaving MAH. At the time of P118's first admission to MAH, I think that his consultant was Dr. H268, Consultant Psychiatrist. This admission was organised by an approved social worker from the South Eastern Trust.

14:16

14:16

I would have visited P118 for two hours every day when he was admitted to M7. P118 cried every day. The ward was like a prison. It was very dark, there were bars on the window and the staff wore uniforms that resembled prison officers. It was not a nice place. Visits became an absolute dread. P118 and I were both anxious.

14:16

P118 was admitted again in or around the late 1990s or early 2000s when he was around 25 years old and was admitted for approximately 12 months in Ward M7. The purpose of the admission was to reassess P118's medication as his behaviour had deteriorated.

14:16

Dr. H268 lived quite close to our family home. For some reason P118 had gone around to his home on a bicycle, knocked down on his bin and shouted at the house while still on the road. I believe his readmission all stemmed from that. During his admission his Consultant was Dr. H268 and his social worker from the South Eastern Trust was SW17. 14:17

P118 was discharged after about twelve months to live at home with me and my partner. I sent a letter to P118's Consultant requesting his discharge, which was granted. I wanted to see if we could get P118 more settled, which did not happen. 14:17

P118 was living alone in the family home for around 10 months until he was re-admitted to MAH in July 2009 with support from myself, his sister and her partner. I would have visited him in the morning, during the day and then last thing at night. I organised his personal care, his food, his clothes and his medications. At the weekend, his sister and her partner stayed with him for the whole weekend. This arrangement had the support of P118's Psychiatrist Dr. H49, Consultant Community Psychiatrist, who wanted to see if P118 could manage living by himself in a supported living environment. It worked well when our family were present but it was difficult to leave P118 alone. The arrangement of just our family providing support could not be sustained. P118's mental health deteriorated 14:17 14:18 14:18

even with all the help and support and the decision was made for him to return to MAH.

P118 was admitted on the 10th July 2009 to Cranfield 1 ward for less than 24 hours. P118 called himself an ambulance asking for help and was taken to Lagan Valley Accident & Emergency unit. P118 and I were told that Lagan Valley Hospital could not admit him to their psychiatric wards and that he would have to be transferred to MAH. An out-of-hours approved social worker came to Lagan Valley Hospital to assist with the admission to MAH. I drove P118 to MAH accompanied by the approved social worker who travelled in a second car. The admission took place at about 3:00 a.m. and P118 was discharged the next day by Dr. H601. 14:19

P118 was further readmitted to MAH as a detained patient on 13th July 2009. The purpose of P118's admission was again for assessment of his mental health and a review of his medication. P118 was admitted to the Cranfield 1 Men's Unit. The decision to admit P118 was taken by his GP..." 14:19

And you name who that is. 14:20

"...who I understand retired on 31st march 2023. P118 called an ambulance asking for help and his GP then arrived. The GP could not get a social worker and asked me to sign for a detention. It was very

difficult. P118 was 35 years old and a big man and he had started to hallucinate. I remember one day Dr. H268 had said to me that some day it would get too much for me and I would have to ask for help.

14:20

When P118 was admitted in July 2009 it was hoped that with treatment, he would be able to return to live in the community. The family house was available for him. We hoped that he would be able to live there with the support of care staff. However, P118 remained detained in MAH for nearly eight years. At the time of P118's first and second admissions to MAH, the wards were old and Victorian. The wards were very small with windows that had bars across them on the outside to prevent opening. M7, the Admission Ward, had small barred windows that prevented light and ventilation which made the ward dark and uninviting. The ward felt more like a prison with patients sharing dormitory-style bedrooms which were usually noisy which, all-in-all, gave no relief to any of the patients with mental ill-health in receiving the peace and quietness they required in making a recovery.

14:20

14:21

14:21

The staff presented more like prison wardens instead of hospital staff who should have been showing empathy and compassion to their patients, especially to someone as young as P118, who was on his first admission. Instead, they looked tough and unwelcoming with their very short hair, white shirts, dark trousers and boots.

14:21

We were pleasantly surprised when P118 was readmitted in 2009 to see that some of the old Victorian wards had been replaced with new spacious wards with larger windows to give plenty of light to improve the well-being of the patients and staff working in them. The windows did not have bars on them, opening out a short distance only to give good ventilation, a welcomed all round change for the good and welfare of the patients. 14:21 14:22

Staff were wearing recognised uniforms. The reception area was also large and well lit, having a very pleasant receptionist who appeared to know the names of all patients and staff. This made it very welcoming indeed on entering the building. I was hopeful that P118's admission to the ward would be different this time. 14:22

If a patient objected to the staff's very strict routines they were frog-marched in an unkindly manner and pushed into the seclusion room and left there unattended until the staff decided to let the patient out again. P118 was able to tell me in great detail how patients were put into seclusion. It happened quite frequently. 14:22 14:22

There was a lot of shouting and other verbal abuse from staff towards patient all of which instilled fear in

the patients. I felt that P118 became so fearful of staff members that he would not ask or even explain how he was feeling to staff because he was afraid of being told off or laughed at, which was often used as psychological abuse with patients. 14:23

As P118 has autism, he is unable to understand or read facial expressions. This meant that he had became confused, frightened and terrorised when someone was being abusive or unsympathetic towards him. He was not 14:23 used to that treatment at home.

After each admission to MAH, P118 found hospital wards very frightening and stressful. He spent a lot of time crying both in the wards and at visiting time, wanting 14:23 to go home because he was afraid of both staff and patients.

Although the surroundings had changed when P118 was admitted for the fourth time, the staff's attitude and 14:23 behaviour towards the patients had not changed. The staff carried their old habits from the old to the new environment. Staff continued to use punishment as a tool towards their own gains and advantages. Kindness, empathy and compassion was in short supply for many 14:24 patients. I wish to clarify that not all the staff working in MAH fell into the category of being loud and abusive to their patients.

There appeared to be a greater number of staff working within the new wards with a good mixture of both gender and age. I felt that incidents were not being reported by staff. One of the reasons why I suspected that incidents were not being reported, particularly by junior staff, was that there were many staff members from the same family. I suspect that if two staff who were working together and were related, incidents of abuse were not being reported. I was also aware that there was a great sense of fear not only displayed by the patients but also the junior staff members. One junior staff member came close to talking about what was happening but appeared to stop from giving out the information. I think it was because she was afraid. There was a palpable sense of fear and secrecy in around the wards. 14:24 14:24 14:24

P118 was in Cranfield 1 and Killead Wards. He was also admitted to PICU on multiple occasions. We were told that he was being admitted to PICU as his behaviour was aggressive and very disruptive. We were not informed properly about what had triggered to P118's behaviour which led to the perceived need to place him in PICU. 14:25

Throughout P118's stay at MAH he remained a detained patient. We were told he was being detained for his own well-being and safety. We were told that because he was able-bodied and he could have walked out, they could not stop him without being a detained patient and 14:25

this would have created a risk to P118.

We did attend Mental Health Review Tribunals, maybe one or two of these during his third admission. This was in or around 2002. The hospital provided a solicitor who represented P118. It was my understanding that the purpose of the Review Tribunal was to see if P118's mental health had improved but it had not. If anything, it had gotten worse. 14:25

14:26

I am a retired nurse. I worked as a nurse for 36 years in Musgrave Park Hospital and Lagan Valley Hospital. I question the training levels and nursing care ability of the staff at MAH. They seem unable to properly recognise when a patient may be ill and require medical attention. 14:26

Many of the patients engaged in swallowing inappropriate and often dangerous objects. This is something that P118 had not done before his admission to MAH. In or around 2010 when P118 was based in Cranfield 1, he swallowed two batteries, one of which he discharged but the other lodged itself in the bowel. Staff were not checking for the second battery to be passed. As a result, it remained in his bowel where it leaked and caused a large inflammatory abrasion with an accompanying abscess in his bowel. P118 became very unwell but the staff were very reluctant to have him seen by a doctor. 14:26 14:26

I recall having to beg a night nurse to get P118 seen by a doctor or taken to Antrim Area Hospital. The nurse initially refused and told me that a doctor would be on shift later. I later learned that there was no doctor in MAH during night shifts at that time. The night nurse telephoned me in the morning to say that P118 was very unwell and he was on his way to the hospital. An x-ray taken in Antrim Area Hospital showed that P118 required surgery immediately. The surgeon telephoned me to inform me that he was going to have to remove part of P118's bowel but he hoped he would not have to do a colostomy that would leave him with a colostomy bag for the rest of his life. 14:27 14:27

The consultant telephoned me after he got out of theatre to inform me that the surgery had been successful, that he removed part of P118's bowel but he had not had to carry out a colostomy. 14:27

Since P118's discharge to a resettlement place..."

which you have named there.

"...his then psychologist, H602 in the South Eastern Health and Social Care Trust informed me that P118, like other patients who swallow batteries, did it because they wanted to get out of the situation whereby someone was hurting them. I was told that it was 14:27

regular occurrence at MAH and that P118 also broke CDs or DVDs and tried to swallow them to try and kill himself. I was shocked that P118 had resorted to anything so desperate. This was all behaviour learned in MAH. 14:28

It was not until P118's fourth admission to MAH that anyone thought to a range of P118's brain to try and identify the source of his behaviour and assist with directing his treatment. Instead, the form of 14:28
treatment P118 received whilst in Muckamore was predominantly administration of medication.
In or around 2011, P118 was referred to the Royal Victoria Hospital for a brain scan. The scan showed that P118 had developed before birth an arteriovenous 14:28
malformation in the front lobe of his brain which was inoperable. I was told that this malformation impacts on communication and behaviour skills. I had been told that there is a 1% increase in risk each year of a brain haemorrhage. 14:29

This is the only official diagnosis that I have ever received about P118's brain function and conditions.
When P118 was assessed at The Royal, the Consultant Neurologist could not understand why P118 was 14:29
prescribed so much medication and in particular such a high level of Epilim. The consultant apologised to P118 and promised him that they would oversee that the number of drugs prescribed would be reduced. He said

they would request the withdrawal of Epilim as P118 did not require it.

The drug was not withdrawn but only greatly reduced. P118 continues to be administered a large amount of 14:29
medication and I am concerned about their effect on him, especially after being informed that at least one of them could be removed altogether.

I felt that after the brain scan and the diagnosis that 14:30
the care plan at Muckamore did not change. The staff at Muckamore never told me that they received a letter from the Consultant about the reduction of P118's medication. Staff did not seem accepting of it or it's implications for his care. I believe that the risk of 14:30
rupture should have been considered, explained to staff and factored in to P118's care as I know of someone who had an intravenous malformation in the front lobe of their brain who suffered two brain haemorrhages.

14:30

In or around 2014 or 2015, I discovered that P118 appeared to be suffering from a chesty cold.
I requested P118 be assessed by a doctor. I was promised that P118 would be seen the following morning.
From my own nursing background, I recognised that P118 14:30
was becoming very will. Despite assurances from staff when I returned the next evening, P118 still had not been visited by a doctor. I was again promised that he would be seen in the morning.

The following evening, I found P118 extremely unwell and he still had had not been seen by a doctor. I requested he be seen immediately and stated that I would not leave until this happened. The Staff Nurse was very hesitant in getting a doctor even though she was aware that P118 was very congested. I recall her saying to me that P118 only needed a drink of water and went and got a glass of water. I told the nurse that I would not be leaving P118 until he was assessed by a doctor. The nurse pulled a face and eventually went to get a doctor for P118. The doctor then requested P118's observations to be taken and within minutes of her checking his observations, a doctor crashed through the door and came to P118's aid. It was like something you would see on television. The doctor diagnosed P118 with double pneumonia and proceeded to inform me that he was having him transferred to Antrim Hospital for admission and treatment as soon as possible. 14:31 14:31 14:31 14:32

P118 was extremely ill for the next two weeks and had to be nursed for four days in the ICU unit in the hope of saving his life. Thankfully he recovered. An MAH staff member who had sat with P118 in Antrim Hospital told me that another patient, who was admitted a short time after P118, and while P118 was still an in-patient in Antrim Hospital, had also been diagnosed with pneumonia and sadly died. If I had not insisted that I wanted P118 to be seen by a doctor before I left on the 14:32

third day, P118 would not be here with us today.

When P118 returned to Muckamore after his discharge from Antrim Hospital, I requested an interview with Dr. H40, the Consultant. I attended a meeting with him, together with my daughter. H12, the ward manager from Cranfield Mens Ward accompanied Dr. H40. I told Dr. H40 and the ward manager that this was the second time that P118 had come very close to death owing to neglect of care at the hospital. I asked what he was going to do about it as our family were concerned regarding P118. He said that the Ward Manager had come up with the idea of getting P118 extra help. That meant that one member of staff, usually a junior staff member, would always accompany him during the day and night. He said that this would mean that if P118 was having a problem of any kind he would this staff member who would sort the problems out as they ensued. Funding was requested and agreed with P118 being granted a one-to-one staff member with him for the remainder of his stay in the hospital. 14:32 14:33 14:33 14:33

P118 developed Type 2 diabetes in or around 2015. Since P118's admission to Muckamore in 2009, P118's diet and whole way of life was largely under the control of Muckamore. I became concerned about P118's lack of exercise. I believe it was a contributor to the development of his diabetes which I regarded as avoidable. I requested many times for exercise to be 14:33

incorporated into his routine but nothing was really done to avoid or manage his diabetes through diet and exercise.

I requested an interview with ward management after I saw a junior member of staff, whose name I cannot recall, was shouting abusively towards P118. A few weeks after this incident, security cameras were installed in the communal day and dining areas. I was interviewed by the Assistant Ward Manager, H79, who was accompanied by her senior Staff Nurse, H459. P118 had told me that H79 and H459 were abusive towards him and other patients as they both regularly shouted at them. P118 explained to me this was very frightening for him and the other patients. Shouting at patients was a regular abuse by some staff to patients.
During the interview they listened to my complaint regarding the behaviour of the junior staff member.
I was asked for the name of the junior staff member but nothing else was said by either Nurse H459 or H79. 14:34 14:34 14:34 14:35
H79 was the Assistant Manager and let Muckamore in 2016 or 2017 to nurse in England.

P118 later informed me that I had wasted my time as the two staff mentioned continued to shout and be abusive towards their patients. Other patients' family members expressed to me their concerns of abuse that was going on in the wards. Staff seemed to take absolute delight in triggering and annoying patients. 14:35

On one occasion P118 was forced to the floor and then dragged by staff members along the corridor from his bedroom to the day space. This was apparently prompted by him sitting quietly in his bedroom listening to his radio when they wanted him to come up to the day space which was noisy and unsettling. They ended up disallowing him his radio and taking it from him. P118 has a routine of music programs that he loves to listen to every day. Due to his autism, routine is extremely important to him. I felt that this was not considered but that the staff routine took preference. This type of change to P118's routine often triggered him and then was called bad behaviour. When we would have been informed that P118 had a bad behaviour we would have asked who was on duty and it was always the same staff; H79 and H459. 14:35 14:36 14:36

P118 was forced into a seclusion room by staff members for bad behaviour. This occurred on numerous occasions. I was shocked to listen to a director in Muckamore speak on television, BBC News, that the seclusion room was only used on rare occasions as this was not my experience. 14:36

One evening, P118 was forcefully pushed into the seclusion room because he asked for a chocolate biscuit with his tea. He was shouted at and made to feel awful in front of all of the other patients who were all

allowed a biscuit. He was forced into the seclusion room at 7 p.m.. He was not allowed out either by the day staff or the night staff until 12.30 a.m. the following morning. He was kept in the seclusion room with its padded walls and floor with only one chair to sit on in the room without a cup of tea or drink of water. He did not receive any supper or the facility of a nearby toilet. P118 also missed his favourite radio show which airs at seven to 10 p.m. which would have greatly increased his anxiety and distress. When one of the PICU staff, H603, came to the door of the seclusion room, she laughed and jeered at P118 through the window. P118 said he asked to use the toilet. However, H603 just walked away saying: "We have got you now." P118 was so afraid of staff shouting at him if he wet his clothes, he told me he made the decision that he would urinate on the floor instead. It was only when P118 was exhausted, calling and crying for staff to come and let him out to go to bed that they finally let him go to bed at 12.30 a.m..

P118 was often put into the seclusion room whilst he was in PICU. This caused him further physical and mental distress as the room itself was not therapeutic and the staff did not look after him when he was placed there.

P118 also dreaded the medicine rounds when Staff Nurse H459 was the one administering the tablets. P118 told

me that she always hurt his mouth by forcing a medicine glass between his lips and forcing him to swallow multiple tablets all at ones. I had been informed by the speech and language therapist that P118 had a poor swallow and required to have his medications administered one by one on a spoon at each medicine round." 14:38

Skipping then to paragraph 50 at the bottom of that page. 14:38

"One of the medications prescribed when P118 was home had been greatly increased in terms of its dosage on his admission to Muckamore. I felt P118 was very sedated with the amount of medication that he had been prescribed. I felt that this was a means of managing him rather than treating him. This greatly annoys me because very often the staff do things to trigger P118's behaviour in the first place and then say that medication or seclusion are necessary to control behaviours which staff themselves have caused. 14:39 14:39

As well as mental abuse, P118 endured physical abuse from various staff members while in his bedroom and shower room. P118 informed me that on one occasion, two care workers, H604 and H605 were supposed to be supporting him to shower, dress and go to the toilet. P118 had requested help with toileting from H604 and H605 but they refused to help him. As P118 did not 14:39

want to be left unclean he again requested help. He was told by one of the staff members to do it himself. This refusal created a trigger which resulted in P118 shouting at the staff to come and help him. At this point H604 caught P118 around the neck forcing him against the wall. P118 was then forced to the floor where the other staff member, H605, kicked P118 with his booted foot in his buttock area. P118 was in the Killead ward when this incident occurred. 14:40

I reported the incident to the senior Staff Nurse called H606. He promised to investigate the incident and speak with the staff. I was not informed any investigation ever occurred. In any event, the two staff members involved remained working at the hospital. H606 was moved to another ward soon afterwards. P118 was afraid to report the incident as he thought the two staff members would come back and attack him again. 14:40

I felt that staff were not properly trained in restraining techniques. After being restrained, P118 would complain for days of either knee pain or painful fingers or neck pain. I also felt that mishandling of patients could be avoided if staff were prevented from creating triggers for patients by their own poor behaviour. 14:41

On another occasion P118 told me that a male care worker whose name I cannot recall was working with him

one morning while showering and toileting and had caught him in the genital area and put him to the floor. P118 was unable to tell me what else happened. He just said the care worker told him that if he reported the incident what he would give him more. 14:41
This threat led him not reporting the incident until he saw the man while shopping with staff in Antrim. P118 said the man was smirking at him and he made the decision to report the incident as he had not seen him working around the hospital. I told P118 that I would 14:41
report the incident. I was contacted by a hospital safeguarding nurse called H607.

I told the safeguarding nurse what P118 had told me about the incident. I asked if this male member of 14:42
staff was still a member of staff at Muckamore. H607 said she did not know but advised that she would find out. H607 later advised me that this individual was no longer working at Muckamore. I also asked if she knew if this man was now working with vulnerable adults or 14:42
children. H607 said she was unaware if he was employed and promised to find out. She telephoned later to inform me that the man was not working with vulnerable adults or children. She did state that she was reporting the incident to police. P118 was interviewed 14:42
sometime later by a police constable with a social worker named SW18 who is currently P118's care manager within the community. SW18 remained in that post until the beginning of 2022.

P118 told me about the incident after he had been resettled out of Muckamore to a resettlement place which is run by the Priory Group where he currently lives. He told me that a male staff member whose name 14:43
I cannot recall was supervising him overnight in his bedroom. Whilst he was asleep during the night, the staff member awoke him as he got into P118's bed. He then proceeded to put his hand on P118's genital area. P118 was crying as he was afraid in the darkened room 14:43
with the door closed. He said the man stayed for quite a while in his bed. I asked if he had reported the incident to the staff either day or night. P118 said he did not as he felt they would not believe him as the man came across as a nice man. This staff member has 14:43
been sacked from Muckamore because of an incident with another patient. P118 told me that this staff member used to escort him to meet me in the visiting room.

P118 also told a resettlement place staff member about 14:43
this incident. This information was provided to the supervisors at the resettlement place who told P118's Care Manager, SW18. The incident was reported to the Belfast Trust's Adult Safeguarding Team. H254 contacted my daughter in September 2020 to inform me 14:44
about the next steps in relation to investigation and procedure.
Due to Covid 19 restrictions, an ABE interview with P118 only took place on 4th April 2022. Our family

have not been told about the outcome of the interview.

The shortage of staff was a regular problem at Muckamore. One staff member confided in me what they could be asked after working all night on duty to go home and have a few hours sleep and come back after lunch for duties until 8 p.m. that evening at the hospital. I did not think this was a safe practise for either patients or staff. 14:44

My family and I believe that P118 was held in Muckamore for too long. We feel what he could have been resettled much earlier with an appropriate community support package, particularly as the family home was available for him. 14:44 14:45

I discussed with now retired social worker SW17 of the South Eastern Trust with regards to P118 returning on discharge from Muckamore to his own home..."

14:45

And you say where that is.

"...along with one or two other adults, all of which would have a package of care to support. SW17 felt that it was not a consideration as it had been P118's home and he may not want to share it with others. I felt that SW17 dismissed P118's return to that place much too lightly. 14:45

I later became aware that plans were ongoing with regards to the planning and building of two apartments as sheltered accommodation, premises known as..."

And you name those, and I will be referring to them, as I already have, as the resettlement location. 14:45

"The resettlement location was at this time accommodating six other residents. The care provider was called Priory Group. There was a temporary care manager called...." 14:45

And they are named.

"The temporary care manager was more interested in meeting the needs of management in Muckamore in supporting getting as many patients as possible out of Muckamore as the media had been highlighting the number of patients in Muckamore for many years without a discharge procedure in place. It was the temporary care manager who liaised with Dr. H40 regarding the planning and overseeing of the two apartments. 14:46 14:46

P118 was never asked if he would be happy living at the resettlement location. I was invited to visit the new apartments. On arrival, I was shocked as it looked like a prison cell. It looked dark and claustrophobic with no view at all. It was not suitable for someone with mental and physical health problems. I feel that 14:46

it has contributed to the deterioration of P118's overall health in the last six years. We were not consulted in the planning process and we were told that is where he was going and there was no alternative.

14:46

With the knowledge I now have of the neglect and abuse that P118 suffered, I believe that much of his challenging behaviour was a response to that and the staff misread or misinterpreted his behaviour. Had he been treated properly or had there been any attempt to understand what might be triggering his outbursts, I believe he could have been discharged back to his own home with a support package.

14:47

In 2017, P118 was discharged to the resettlement location. I believe P118's discharge should have involved a proper explanation of P118's diagnosis of brain arteriovenous malformation and its implications for his care. This was not done, and our family has had to verbally remind everyone supporting P118 of this diagnosis.

14:47

On the 20th June 2020, the Priory Group gave P118 his 28 day notice to leave their care. Our family were unaware that P118 was apparently under some sort of six month review period between the Priory Group and the South Eastern Trust. Co-incidentally, I had real reason in reporting the uncleanliness of P118's apartment as well as his poor diet on many occasions to

14:47

his Care Manager SW18. Even though I had expressed my concerns for P118 already to all levels of staff at the resettlement location, our family appealed the Priory Group's decision as they were requiring P118 to leave in the middle of a pandemic and without any discharge plan. The Priory Group rejected the appeal.

Several Best Interest Meetings were held between family, Prior Group and South Eastern Trust during which our family made it clear that P118 would not be leaving the care of the Priory Group until a discharge plan was created, naming his next appropriate accommodation and providing appropriate care support. The Priory Group continued to put pressure on our family verbally and via telephone calls to remove 118 from their care. 14:48

P118 is now seeking his secondary settlement back to his home area..."

And that place is named. 14:48

"...with a support package. There was little or no formal written correspondence received by our family regarding any of P118's admission. Communications about admissions consisted of either face-to-face meetings or telephone calls with Muckamore staff and/or South Eastern Trust social workers. 14:49

In my view, given the importance and significance of an admission to a psychiatric hospital, the family should

be provided with paperwork setting out the date of admission, reason for it, the likely duration, what is likely to happen, the ward, and the consultant psychiatrist responsible for their care. In due course I believe that paperwork should be provided setting out any diagnosis and the care plan. Important procedures such as those relating to restraint and seclusion should also be explained and any guidance about them provided, as should the complaints process. None of this happened through all P118's four admissions and discharges. 14:49 14:49

During P118's time in Muckamore he had several personal items stolen such as his CDs and his DVDs. No explanation was ever provided nor were the items ever recovered. 14:50

P118 had his own bank account and he managed this with my help. Generally there were no problems with misappropriation of money but I helped P118 with his bank account and sometimes requested receipts from Muckamore for anything they bought with him. 14:50

P118 did not have an advocate in MAH. After discharge we learned that he could have been provided one through the Belfast Trust but we were not informed about these services at the time. At the last meeting before discharge from Muckamore, I was approached by a male advocate employed by Bryson Care who handed me a 14:50

service card if P118 required assistance on discharge. Our family did in fact require these services and they continue to provide services and support in which we are very grateful for. P118 is most of all grateful. We were not told at any admission stage that we could have had the support of an advocate.

P118 was admitted to Muckamore to improve his mental health. However, his mental health deteriorated during his fourth admission and the eight years he spent there. I believe this was due to the lack of care and abuse he suffered there." 14:51 14:51

I am going to skip the next paragraph and then after that, P118's Mum, you gave a declaration of truth where you confirm the contents are true and correct, or true to the best of your knowledge and belief, and you sign and date the statement. 14:51

Okay, so I am going to ask you two very straightforward questions, hopefully, okay. Are you content that what I have read out there is accurate? 14:51

A. Yes.

96 Q. And are you content to adopt that as evidence to the Inquiry? 14:51

A. I am.

MS. BRIGGS: Chair, Panel, that concludes the open session of this part of this witness's statement.

CHAIRPERSON: Yes, certainly. We have got a nice

photograph, I think, at page 21 but we have looked at that. So there's a photograph.

A. Yes.

CHAIRPERSON: And we have had a look at. So shall we go into restricted session which I think we can do very quickly? 14:52

If we cut the feed to Room B please.

THE HEARING WENT INTO A RESTRICTED SESSION

14:52

THE HEARING WENT INTO OPEN SESSION

P118'S SISTER HAVING BEEN SWORN WAS EXAMINED BY MS. KILEY AS FOLLOWS 14:55

97 Q. CHAIRPERSON: I am going to refer to you as P118's sister.

A. Yes, that's right.

CHAIRPERSON: All right. So welcome to the inquiry and I will hand you over to Ms. Kiley who I know you have met. 14:55

98 Q. MS. KILEY: Good after, P118's sister. We met briefly earlier this afternoon and I explained the procedure for giving evidence. I am referring to you, as you have heard, as P118's sister, and we have discussed the reasons for that. You, I know, are going to try to refer to your brother as P118. That can be difficult and if you want to refer to him just as "my brother" 14:55

then that's absolutely fine too. So as you know, the first thing that I have do is read out your statement. You should have a copy of your statement in front of you there and then just above that, you will see the cipher list as well. As you know, I am not going to be saying some of the staff names so if you want to follow along, you will see the ciphers there. So are you ready for me to commence reading now and then I'll ask a few questions? 14:56

A. Yes, okay. 14:56

99 Q. Thank you. So you made your statement, it's dated 24th August 2023, and you say:

"I, P118's sister, make the following statement for the purpose of the Muckamore Abbey Inquiry. 14:56

My connection with MAH is that my brother was a patient in MAH. The relevant time period that I can speak about is four separate periods between approximately 1983 to 2017. I am the sister of P118 who is currently 14:56 aged 49 years old. My mother, P118's mother, has also provided a statement to the inquiry.

P118 was born with severe learning difficulties, accompanied with autistic symptoms. P118 has good 14:57 communication stills. He understands right from wrong and knows if he is being mistreated. P118 is verbal. Before P118 was admitted to MAH, he lived at home in the community. He is about 5'9 inches in height. He

was fit and healthy. He enjoyed cycling and could have cycled 30 miles in a day.

I wish to address those issues with which I have had specific dealings. P118 is now seeking resettlement back to his home area with a support package and I have been assisting with this. This would be P118's second resettlement from leaving MAH since 2017. 14:57

I think that leadership was an issue in MAH. The leadership was not there to ensure staff were able to deal property with P118. Whilst P118 was in MAH between July 2009 and May 2017 I visited him twice a week. This was to give P118 emotional support and interact in positive activities to assist with his mental health recovery. We did trips to the cinema, picnics, car drives, walks with my dogs and went out for dinner. We also enjoyed Christmas stay-overs. I provided P118 with these activities as I believed he required private family time together and respite from the ward environments he was being exposed to and treated in, within MAH. These activities also provided P118 with relaxing sensory needs for a healthy well-being and mindset. Our family currently carry out the same activities today. These activities with family gave P118 hope and something to look forward to during his very long treatment in MAH. 14:57 14:58 14:58 14:58

Whilst P118 was in MAH, I observed P118 demonstrating

signs of being heavily medicated. For example, his eyes rolling in his head, slurred speech, falling asleep quickly and tripping over his own feet when trying to walk. I asked ward staff on numerous occasions why P118 was displaying these signs. I was always advised that P118's behaviour that day required further medication which I now know is called PRN treatment to manage the situation. 14:59

When I enquired what P118 had done to require further administration of medication, the staff response was always negative towards P118's behaviour and presentation. For example, it was P118's own fault that he needed further medication because he was shouting or kicking out at staff. I never heard hospital staff being accountable for any of their own actions during any of these incidents. I would refer to this treatment type as chemical control and a highly inappropriate response to manage an unsettled moment in P118's life, bearing in mind the situation may have been triggered by a member of staff. 14:59 15:00

P118 would have regularly disclosed to me what staff would upset him daily. P118 felt frightened. He said staff would laugh at him, shout at him, they swore at him and had punched him. P118 had explained to me that he had told staff that he was not a punching bag and to stop it. He told me that staff just laughed and walked away. 15:00

If I questioned nursing staff, it was always dismissed with the explanation that incidents started with P118 and his presentation on that day. I was also advised that P118 fabricated stories to get staff into trouble. 15:00
I know P118 and I know this to be untrue. P118 had also explained to me that staff would have taken his treasured radio away from him while sitting relaxing and listening to a favourite radio show. P118 uses a radio for sensory needs. He finds the radio a 15:01
comforter and the music is a soother. P118 continues to enjoy this activity today. The staff at MAH would not have taken this on board. They would have taken P118 away from his radio to engage in some other activity, for example, saying that he had to watch TV. 15:01
This would trigger P118 and they would then describe P118 as being aggressive.

P118 also would have told me that the staff would have put his earphones on him while listening to the radio. 15:01
He told me that they would turn the volume loud so that he could not hear what they were saying. They would tell him not to listen to them. I believe this could have contributed towards hearing problems that P118 has developed. 15:01

P118 is very aware when an individual is being overpowering by their own physical and mental attitude. I believe that these behaviours from professional MAH

staff had an enormous detrimental effect on P118's mental health, bearing in mind this environment was meant to be professional safe space for treatment and recovery.

15:02

I observed P118 being stripped of any form of confidence he ever had by exposing him to unkind environmental hazards, the product and service created from the lack of leadership and knowledge from all management levels within MAH. I strongly believe 15:02
P118's treatment could have been shortened if he had received a better planned relaxing sensory environment filled with nursing empathy to support his care needs.

Instead, I observed P118 receive his treatment in a 15:02
noisy, harsh, unsympathetic and chemically controlled environment. I believe that this also put P118 at further risk from abusive behaviours created by staff within the site. This era of P118's life was harrowing. 15:02

During P118's treatment in MAH he never told me about any sexual abuse he was enduring. I believe P118 was too troubled to make me aware of such incidents. However, in the summer of 2020 he did disclose to me an 15:03
incident about a past event that occurred whilst he was in MAH between 2009 and 2017. At this time, I did not know about the incident P118 was referring to as P118 had reported it to support staff member in the

residential facility where he currently resides. The staff member, named H890, had reported this information to the management where he resides. They then reported it to the South Eastern Trust, who began the investigations with the Belfast Trust and the PSNI. 15:03
Unfortunately, when P118 was interviewed he did not disclose enough detail about the sexual incident for the investigation to move forward. I was updated via phone call from the PSNI and The Belfast Trust. No written correspondence was ever forwarded regarding the 15:03
position or outcome from either department.

I have essentially taken over as P118's next of kin from my mother since the beginning of 2020 regarding care related concerns within the facility of the place 15:04
that P118 currently lives. P118 was transitioned to that place from Muckamore in May 2017 as his resettlement in the community.

During this time, I have learned about the lack of 15:04
medical information and care needs that were not disclosed to the new facility from MAH and The South Eastern Trust. There have been numerous times during care review meetings that P118's presentations have been seriously misrepresented by either Trust staff or 15:04
the other facility staff.

What I heard and read during these meetings did not describe P118. I believe it was describing a person

who had been failed by the State when seeking professional assistance for their mental health, only to be thrust into a world of mental, verbal, physical and sexual abuse from within MAH. I believe the toxic experiences within MAH gave P118 learnt behaviours, something which he never had before entering MAH. I also believe they misrepresented P118's true personality and needs. 15:05

I have experienced very challenging times with the new facility regarding P118's care. I believe a degree of this was caused by MAH and their misdiagnosis of P118. For example, elements of P118's care plans did not support his needs relating to personal care and consideration of P118's inoperable arteriovenous malformation and neglect by the other facility who did not follow through on set plans either. 15:05

I am upset about how P118 has been treated. His current living situation is based on his behaviour but I have never had any problems with P118's behaviour when he has stayed with me or in my company. I believe that the Trust has graded P118 unfairly and that the behaviours he has exhibited were caused by the staff in the Trust and their failure to treat P118 properly. 15:05 15:06

In terms of resettlement, the process has been very frustrating. The resettlement facility should have properly trained staff with knowledge of how to treat

people with learning disabilities, but they are no fitter than anybody else to look after P118. Many of the issues are environmental and sensory. The resettlement facility is very depressing and this is very difficult for P118. During Covid, P118 was presented with his notice. His behaviour had become extreme because he could not see his family in person. This caused his behaviour to change and so the manager phoned and said that she did not know what do and she was going to phone the police. This surprised me because they are meant to be the experts but she did not seem to have a clue what to do. I felt it was inappropriate for her to even make that suggestion. I am very disappointed that p118 is still there and it has not worked out. 15:06 15:06 15:07

I believe what failures in P118's care began with lack of leadership from every level of management within the Belfast Trust and South Eastern Trust. I am upset at how P118 has been treated. P118's current living situation is based on his behaviours at MAH. I believe that the Belfast Trust and South Eastern Trust graded P118 unfairly and that the behaviours he has exhibited were caused by the staff in MAH and their failure to treat P118 properly. 15:07 15:07

MAH did not provide the adequate environment p118 required for his treatment plan. I believe that they relied heavily on chemical control to manage P118 in

these unsympathetic environments. I never felt assured or confident that MAH knew what they were doing. I also feel the same way about the facility P118 presently resides in.

15:07

I feel traumatised by what has happened in MAH to P118. I feel that I have neglected P118 letting him be in this place and I feel guilty as a result. P118 is now 50 and he has heart failure. I want his situation to be resolved as soon as possible so that he can live 15:08 happily for the rest of his life."

You then, if you turn over the page, give a declaration of truth and sign your statement and there are no exhibits to the statement. So P118's sister, having 15:08 heard me read that out, first of all are you content that the contents of your statement are accurate?"

A. Yeah.

100 Q. Would you like to adopt that as your evidence to the Inquiry? 15:08

A. Yes.

101 Q. I'm not going to ask you to repeat everything that I've just read out but there are a few issues that I just want to ask you some additional questions about, okay. And the first is about what P118's life was like in 15:08 Muckamore. You described him as being an active person before going into Muckamore and you described he particularly enjoyed cycling. What opportunities for activity, and physical activity in particular, were

there whenever P118 was in Muckamore?

A. I believe that they had a swimming pool which [name] my brother....

102 Q. Don't worry, we are just going to pause and we are going to rectify the feed and the transcript. As I said to you before, it is nothing to worry about, this happens all the time. You just said there that you understood that there was a swimming pool at Muckamore and that you were going to tell us something about your brother connected to that? 15:09

A. Yes, the swimming pool was available, I'm sure possibly every day but it may have been a stage in [names brother]'s life.

103 Q. Don't worry. Okay, as I said it might be easier just to say "my brother". 15:10

CHAIRPERSON: Hold on a second. Just pop that in front of the witness. I should have done this ages ago! It just says "my brother" and it seems silly but it will actually help.

A. Thank you. 15:10

CHAIRPERSON: Please don't worry, everybody has done it .

A. I think probably because it is important because he is a person.

CHAIRPERSON: Exactly, we totally understand that. 15:10

104 Q. MS KILEY: Okay. So the feed has started up again. Can I ask you to start again at the swimming pool please.

A. Yes, the swimming pool was made available to my brother

which would have been, to me, the only form of exercise that my brother was introduced to. I don't believe there was any other exercise introduced to him. That's where family would have took my brother out for walks, around the complex or out within facilities where we felt he was able to enjoy those type of activities where the ground was flat within a time period that would have been appropriate to him that he could obviously take part in that time period. Other than that, I don't believe there was anything else offered. I certainly wasn't advised of any other activities that may have been offered. 15:11 15:11

105 Q. Do you know how often he would have used the swimming pool?

A. No is the answer, and it wasn't for the entire time he was in the hospital from 2009 to 2017, that was over that period. How often I don't know. 15:12

106 Q. CHAIRPERSON: Can I just ask while we are on that, I'm sorry to interrupt Ms. Kiley, but when he was living in the community he could cycle. 15:12

A. Yes.

107 Q. CHAIRPERSON: Somebody would have to cycle with him?

A. No.

108 Q. CHAIRPERSON: So he could cycle on his own?

A. Yep. 15:12

109 Q. CHAIRPERSON: Quite safely?

A. Yes.

110 Q. CHAIRPERSON: And get himself back home.

A. Yes, yes.

111 Q. CHAIRPERSON: Until when?
A. Until it got too dangerous on the roads where it was just unsafe for him to do so. Therefore, he then stopped himself because he knew it was -- the gauge of traffic. 15:13
112 Q. CHAIRPERSON: But in a safe environment he could have cycled?
A. But in a safe environment, yes, he could have. As I say, he could have maybe cycled 30 miles in a day if he wished to do so, and had done. And again just giving a bit of content, that was on a mountain bike with quite a lot of gears to it and he done it in second or third gear, which is a lot of pedalling, to go somewhere. So there was a lot -- he was a fit man at the time, very fit. 15:13
CHAIRPERSON: Thank you. Sorry to interrupt.
113 Q. MS. KILEY: That's physical activity. What about your brother's access to other activities when he was at Muckamore, did he attend day care facilities or anything of that kind. 15:13
A. Yes, there was a separate building which was the sensory needs building, as far as I am aware, that is certainly what my brother referred to it as, and he really, really enjoyed that, I think because, again it was peaceful from the environment of the ward where he could relax a little bit, get away from staff, other patients, so much noise because the ward had really high ceilings which noise echoed in and he wouldn't have enjoyed those types of environments. But the 15:14

sensory room, I think I was in it twice myself, was completely different and he enjoyed that, that was his activity with regards to being on site. Staff would have also have taken him out shopping into Antrim and got a few bits and pieces as another activity. Maybe that was a cross activity where you are gaining exercise to walk to the building and also an activity of purchasing personal items as well, but that was really it.

114 Q. What about behavioural therapies? Did he ever receive anything of that kind, to your knowledge? 15:15

A. What do you mean by that?

115 Q. So perhaps did he receive any therapeutic treatment from a behavioural therapist or it might even have been a psychologist, to your knowledge? 15:15

A. I am not aware that he ever received or was even offered that.

116 Q. Okay. What about your brother's care plan? Did you ever see a formal document of that kind whenever he was in Muckamore? 15:15

A. Again, I personally wasn't shown a copy of that.

117 Q. I want to then move on to the next issue that I wanted to ask you a little bit more about and that is from paragraph 11 of your statement because you say there that your brother would have regularly disclosed to you 15:16 that staff upset him and you give examples there about staff. You say that he told you they would have laughed, shouted, swore and punched him. Whenever your brother made those disclosures to you, did you raise

the issues with staff at Muckamore?

A. Yes, I would have asked the staff who would have then came and got my [name's brother] after....

118 Q. We'll pause the feed for a second. So I was asking you whether, when your brother made disclosures to you, you ever raised those or reported those to staff? 15:17

A. Yeah. When visiting was over, staff would have came to escort [name's brother] -- sorry.

119 Q. So I asked you then about what would have happened whenever your brother reported disclosures to you and whether you reported those to anyone in Muckamore and you were starting to tell me what would have happened after visiting with your brother ended, so will you tell us a bit about that? 15:17

A. Yeah, when staff came to receive my brother, I then put to them what my brother had explained to me, and the answer is either they didn't know because they hadn't dealt with anything or they were unaware or they would enquire from another member of staff what this incident related to. And at times, nobody came back to me or somebody did come back to me but they also weren't aware of what had happened. I don't know if it was a case maybe because of change in shift, timings that they hadn't received a hand-over period for what had happened that day, but everything seemed to be dismissed, was the long and the short of it. You never got any answers as to what actually happened to start something off with [name's brother]. 15:18 15:18 15:19

120 Q. Okay, so I'll ask you to continue what you were just

saying to me, you are saying you never got answers and then you were about to continue?

A. Never got answers, it was always dismissed, it was always dismissed.

121 Q. And when that happened, did you ever consider escalating your concerns beyond staff at ward level? 15:19

A. Yes, I had thought about it, but as far as I was concerned, I was taking it to the manager of the ward for them to obviously come back to me as a concerned relative which at times they would have obviously spoken to me about different elements but again, they maybe weren't on duty that day and they were speaking from -- they were reading from notes that somebody else had created. How accurate those notes were, nobody will ever know and therefore at that point, because it was ward level, on assumption, I thought I was speaking to the right people about it. 15:20 15:20

I know that my mother had addressed different concerns with the doctors in meetings who would have obviously listened but kind of fed that back down the food chain again to the management on the ward. So in respect, kind of went round in circles when you had concerns, which problems obviously still continued throughout that. 15:21 15:21

122 Q. You referred there to meetings that your mother had with staff at Muckamore. Do you know how often they took place?

A. I can't actually say just how often, but meetings took

place when felt needed, really.

123 Q. And so was that the main method of communication between Muckamore and your family?

A. Well, to discuss [name's brother]'s future, yes.

124 Q. Sorry, I will just pause you there. Okay, so I was asking you about the meetings that your family had with Muckamore and whether they were the main method of communication between Muckamore and your family? 15:22

A. Yes, meetings took place to further his care. There was also telephone conversations with myself and ward staff. That also would have happened with my mother as well talking to ward staff, plus face-to-face as well whilst we would have been visiting. 15:22

125 Q. Did your family have a single point of contact within Muckamore with whom you could raise concerns? 15:23

A. I didn't have, no, and there certainly wasn't any names put forward to myself about that either. I don't believe my mother had that either. It seemed to be just whoever happened to be on duty.

126 Q. Were you ever provided with a complaints procedure in respect of the hospital to tell you how to raise concerns? 15:23

A. Again, I wasn't.

127 Q. Another issue that I want to ask you about is the incident that you talk about at paragraph 17 and 18 of your statement, you describe a particular incident there and you say that P118 was interviewed by the PSNI in respect of that, and you then refer to being updated via phone call from the PSNI and the Belfast Trust 15:23

after that. I just wanted to clarify that in your mother's statement, your mother said that the family wasn't told about the outcome of the investigation. Can you just clarify what you were told about the outcome of the investigation after that interview? 15:24

A. Yeah, as stated, the PSNI contact for that particular investigated had made a call to myself to explain the outcome, which unfortunately came to a dead end, and from the Belfast Trust there was also a phone call but no written report from either PSNI or the Belfast Trust 15:25 to deliver a closing report from either came through, it was just verbal phone call.

128 Q. As far as you are aware, is there any ongoing police or Trust investigation into that matter then?

A. No. 15:25

129 Q. No, okay. One of the things that you referred to a few times in your statement is what you described as an issue with the leadership at Muckamore and particularly at paragraph 7, you said that you felt the leadership was not there to ensure that staff were able to deal 15:25 properly with your brother, and I wanted you to ask you to elaborate on what you mean by that, if you can. What did you think that the leadership needed to be doing to be able to deal properly with your brother?

A. Well, that's exactly it, it's the leadership. You had 15:26 a doctor who seemed to be answering [name's brother]'s care with...

130 Q. I'll just stop you there. Don't worry, we will pause the transcript. Okay, so you were telling us what you

meant about the issues about leadership at Muckamore?

A. So you had doctors who were managing the situation through drugs. Then, as far as I am concerned, the next management was the ward staff and those positions within that. They were obviously being directed from the doctor's, I suppose the doctor's view with the use of medication, because it took some years before [name's brother] was given -- sorry.

131 Q. If we just pause. Okay, if I can ask you to pick up there, please. 15:27

A. So it was some years before my brother was given a one to-one for support and I questioned it with the leadership how could he have spent so long in a place when nobody was taking responsibility to look at his care to see exactly, well, what is it that this chap really needs? Is it all this medication? Is it? And it's not taking responsibility, nobody was coming forward with any great plans. He was just existing in the place, day after day after day after day, and it seemed to be nobody wanted to take responsibility of trying something different away from all these drugs that seemed to be given to him. The leadership again, the staff taking responsibility, not taking responsibility, depending on the day who was actually managing the ward, or at night as well, and staff doing double shifts with little rest time in between, people become fatigued, they are not necessarily managing properly, which then is a knock on effect to their leadership skills.

15:26 15:28 15:28 15:29

132 Q. And those issues that you're describing, were they a feature for your brother's period in Muckamore the whole time that he was there or was there particular time that you felt that that was evident?

A. Certainly after the first year, nothing seemed to be changing after 12 months, and that continued that nothing changed up until the point where change was coming in via government.... 15:29

133 Q. There was a partial name.

CHAIRPERSON: You just stopped yourself! 15:30

A. I'm learning.

134 Q. MS. KILEY: Okay. You were describing to me then when you felt that the issue that you have been talking about was particularly evident. If you could pick up with that please? 15:30

A. Yes, where he was being asked to basically move out of Muckamore to the community. Again, some people may say that leadership was highlighted there. However, pressures from the government were put on those, in those leadership positions to actually be a leader and do something, and all of a sudden my brother was then able to be on a programme for resettlement but I don't understand why he had to be in the hospital for eight years, I don't understand that whenever he had his home to return back to. 15:31 15:31

135 Q. And you're saying there you don't understand why that was the case. Did anyone at the hospital ever explain to you why your brother was in Muckamore for the time period that he was?

A. No.

136 Q. One of the things that you mentioned there before you were talking about your brother's move out of Muckamore was what you described as his management by drugs within Muckamore and in your statement, you refer to the use of PRN in particular, so. I want to ask you a little bit about that. Are you able to say how often your brother was given PRN during the period in Muckamore? Was it a regular occurrence? Irregular? 15:31

A. Yeah, it seemed pretty regular. There was a period maybe about 2015-ish, give or take, where each time that we had been visiting [name's brother]... 15:32

137 Q. If we could stop the feed, please. Okay, if I could ask you to pick up. I was asking you about how often you might have noticed PRN being issued? 15:32

A. Yeah, there was a time that every visit he was heavily drugged.

138 Q. Why do you say that? What way was he appearing that made you think that that was the case?

A. As I had stated, his eyes rolling in his head, slurred speech, tripping over his own feet, couldn't really stay awake whilst we were in his company, while we were trying to have a conversation, and if he was able to interact that day, he was probably trying to explain to me an incident that had obviously happened that day, or maybe the night before, because usually with my brother, it's like a 24 hour sort of cycle with the trauma he would receive from an incident, regardless of what the trigger may have been. So if my brother had 15:33 15:33

an incident the night before and was quite upset going to bed, he may have been given medication then to settle him. The next day, he may have awoke still quite annoyed with what happened the evening before, or the day before, and still would have been quite upset 15:34
therefore, again on assumption another dose of PRN may have been administered at that point, or it may not, but regardless, it was incidents that seemed to trigger this extra medication coming in.

139 Q. Okay. Are you saying there was, to your knowledge, 15:35
specific incidents that resulted in the administration of PRN?

A. Yes.

140 Q. How did you know about that? Were staff telling you that incidents occurred and they needed to administer 15:35
PRN?

A. Nobody, nobody actually informed me of different incidents. My brother informed me because he can communicate very well and knows when someone has been unkind to him. Therefore, he would then challenge the 15:36
situation, hence then the knock-on effect that came from that. He may have presented his behaviour in a way that staff deemed unsuitable, but suitable to administer PRN to again resolve the situation.

141 Q. Did your family ever raise concerns about the use of 15:36
PRN with staff at Muckamore at those times?

A. I didn't with the term PRN but I had mentioned it to different staff over that period of time that that [brother's name]....

142 Q. Okay. I asked you if you raised any concerns about the use of PRN with staff at Muckamore?

A. Again, bearing in mind this was verbal, this was face-to-face, there was nothing in writing of any sort, so it was who was ever on duty on a particular day that I had mentioned that [brother's name] -- sorry. 15:37

143 Q. That's okay. Stop the feed again please. Okay, so I was asking you about the reporting of any issues with PRN PRM and you were saying that it was verbal, is that right? 15:38

A. Verbal, yep. That he appeared very drugged. They took that on board. As I say they gave some explanation to whatever that was. I obviously had a conversation about that back with them again, but they seemed to be well educated in giving the answers that you could say fob people off to the extent where that medication was needed. You know, "you weren't here at the time whenever it happened; we were, we had to deal with it, this is how we dealt with it. Medication was given." 15:38

144 Q. And you described various outings that you would have taken your brother on outside Muckamore. Would he ever have needed PRN or medication during those sorts of events and outings? 15:38

A. Never. He has never needed any additional medication whilst in the company of his family, that's then, and currently he never needs that. I never have any problems with my brother, ever. 15:39

145 Q. Okay. And he is now in his new resettlement facility as we have been calling it. How is he getting on

there?

A. That was reasonably fine from his transition in 2017 until 2019. They have problems, management problems as well, which was a knock-on effect to his care. They couldn't get managers in a permanent position there for approximately I think it was maybe two years, two and a half years, so there is a lot of change within that facility and it was very challenging, to say the least, and accepting what [names brother]'s needs -- sorry. 15:40

146 Q. Okay, you were just explaining there was a period when it was very challenging when [names brother]...(interjection) 15:40

CHAIRPERSON: You have just done it now!

147 Q. MS. KILEY: Oh, I am sorry. So you were explaining about the challenging period whenever your brother moved to the new facility. 15:41

A. Yes, simply because of their own management issues and problems came then a knock-on effect then with [names brother]'s care.

148 Q. Okay, so can you tell us again about the challenges that you want to tell the Panel about? 15:41

A. Yeah, with the care provided in his current, in his current respite.

149 Q. His placement?

A. Whichever you wish to call it, he had a lot of -- a lot of trouble really from 2019 onwards, roughly to about 2021, middle of 2021, I took over a lot of that responsibility from the beginning of 2020 because there was just numerous things that were starting to -- duty 15:42

of care was starting to slip and general cleanliness about the place. The food types that were being offered to my brother was poor. They were offering food types to him that suited them but not suited his needs. So that meant that he was eating or trying to eat foods that he didn't like. Therefore, he reverted to negative snack foods, and still does because it's learnt behaviour now, that when he left Muckamore he was query query Type 2 diabetes now, he is full blown because he has had so many opportunities of consuming negative snack foods through learnt behaviour of that time 2019 into 2021 where he could do that to survive. He was smart enough to know that, well, if you are not giving me the foods that I need to eat I know I have snack foods and I can survive on that, which is really sad. 15:43 15:43 15:44

150 Q. CHAIRPERSON: Could I just ask about that? Were these preferences in terms of food? So was it things he just didn't like to eat or were there specifics things that he found physically difficult to eat? 15:44

A. Both. I believe he was being offered like Chinese style cooking, like rib-type foods which wouldn't be to his taste or to chew as well because that is a big factor, problematic where he can choke, and has done as well. 15:45

151 Q. CHAIRPERSON: So it wasn't simply preference; it was a physical difficulty?

A. Yes.

152 Q. CHAIRPERSON: Was there a diet plan or a food plan for

him?

A. At the time, I'm unaware that they had even considered.

153 Q. CHAIRPERSON: To be fair, you don't know, but I think probably the high point you can say is you never saw one if there was one? 15:45

A. No, I'm told that menus were created but when you analyse the menus, they are based around what you believe someone may like or enjoy, not the types of foods my brother would have been used to; i.e. he enjoys porridge, he enjoys salads of any meat selection 15:46 to them. He enjoys proper dinners; vegetables, potatoes, meat, he enjoys all of that. Really good with vegetables and salads but yet was being offered foods that were not familiar to him to even know what they were. If you use the word "fajitas", he would not 15:46 understand what that is, but if you explained that it had the types of ingredients, he would understand then, but make it plain, so.

154 Q. MS. KILEY: Can I just clarify with you on that, was your brother seen by a dietician whenever he was in 15:47 Muckamore?

A. I believe he was, yes.

155 Q. Okay. And you used a phrase in answer to my question earlier, you said that your brother is displaying learnt behaviours. What do you mean by that? You 15:47 referred to them as I think learnt behaviours from Muckamore so what are those learnt behaviours?

A. Well, he understands that to get something -- he understands to get something what he needs to do. So

if, for example, the presentation of the food within his current living arrangement isn't what he is enjoying or would like, he has learnt survival skills from being in Muckamore through the experience he has experienced through that, of how to survive now whilst in the hospital, he had picked up these behaviours that he had never displayed before going into hospital. So where he picked them up within the hospital, I don't know, because I wasn't there, but he had to learn how to survive and some of these behaviours were also a cry for help as in, if I do something so severe that someone will listen to me or see what's happening or I'll be able to leave this ward for at least a day or two, or maybe a week, just to get out of it. So you learn from watching and observing others do things or say things that he has picked up on that and then implemented that himself. 15:48 15:48 15:49 15:49

156 Q. Okay. P118's sister, I don't have any other issues that I want to ask you specifically about. It maybe that the Panel have some questions for you? 15:49

CHAIRPERSON: Professor Murphy.

<u>P118'S SISTER WAS THEN QUESTIONED BY PROFESSOR MURPHY</u>.

157 Q. PROFESSOR MURPHY: It sounded like in 2009 you had a good plan for your brother's long-term care, i.e. a family house with supported living and you tried to put that supported living in yourselves. Did you talk to social workers about the possibility of staff 15:49

support to do that, so that it wasn't entirely on your family?

A. That was the whole point, that my brother had his own home to go back to, there was always a building there.

PROFESSOR MURPHY: Yes. 15:50

A. And for others. It was being opened up to others, it wasn't just about him, to view the bigger picture here. For that to work, there needed to be a care package present to allow that to work. That had been -- my mother had presented that to the social workers at the 15:50 time who immediately reneged on that as stated, that that would be something they believed that wouldn't work. What that actually means, I don't know, because that wasn't clarified and I think the conversation wanted to be shut down because it didn't tick the box 15:51 of how things were done as opposed to maybe what [name's brother]'s needs were.

158 Q. MS. KILEY: Sorry, if we stop the feed please. Okay, we are ready to go again. You were answering Professor Murphy's question. 15:51

A. So my brother's needs, from the family's perspective, were overlooked because there was a building there for him and for others. There was an opportunity, or opportunities, as I say, for not just my brother but for others with the right support from the South 15:52 Eastern Trust to consider that further but that wasn't and....

159 Q. PROFESSOR MURPHY: So they never said to you for example, let's give it a try or?

A. No.

160 Q. PROFESSOR MURPHY: Or give you any particular reason why it couldn't happen?

A. Just the fact that they believed, which is kind of a throw-away comment, "believed". It wouldn't work for him because they couldn't justify putting a whole team of staff there just for my brother, it would need to accommodate other people, which wasn't a problem. They had suggested that my brother wouldn't cope well if there was others within the building but there is lands at the side of the house at the time, there was opportunity for extensions, a bigger build to accommodate that, that it could have been several separate buildings, but all interlinked perhaps to again accommodate, but they didn't want to know. 15:52 15:53 15:53

PROFESSOR MURPHY: Okay, thank you.

CHAIRPERSON: When you were talking about I think the topic you were discussing was leadership, you said there came a time when it took a while to get one-to-one support for your brother and I just want to understand that a bit; how long was he in Muckamore before he got one-to-one support and what difference did that make? 15:54

A. That, I think that came, the one-to-one support came whenever he had swallowed the batteries. Again, I believe that my brother done that to escape the hospital ward, to get out, cry for help. When he came back into Muckamore again, from Antrim Area Hospital, as a family we were obviously very concerned. My 15:54

mother asked for a meeting with the consultant at the time where it was suggested that the way around this to assist that a one-to-one was there to help.

161 Q. CHAIRPERSON: And that happened?

A. Yes. 15:55

162 Q. CHAIRPERSON: Did that help him?

A. Yes, to an extent, to an extent, depending who the person was.

163 Q. CHAIRPERSON: Yes, of course, okay.

A. If there was a good personality match, perfect but there would have been numerous staff that were not. 15:55

164 Q. CHAIRPERSON: Yes, all right. All right. Can I thank you both, if I can address you both, for coming along to tell us about your brother and your son and you've done so, if I may say so, in very moderate terms which has helped us a lot, you have been very factual about it and that has helped. So can I thank you both very much for what must have been a difficult experience, we understand. All right, thank you. 15:56

MS. KILEY: Chair, we do have another witness coming. I am being asked could we take a five minute break. There are issues that this witness -- there maybe something to be dealt with, there may not, but if there is, if we could take a break I can update you at the you the set of the next session. 15:56

CHAIRPERSON: Sure. Well, what we will do is we'll take a 10 minute break, I think, and then you can speak to the secretary of the Inquiry to see if there is anything that you want to add. Is that all right?

Thank you very much.

THE HEARING ADJOURNED FOR A SHORT PERIOD.
THE HEARING THEN RESUMED AS FOLLOWS:

16:12

CHAIRPERSON: Thank you.
MS. KILEY: Chair and Panel members, you will see that P118's mother is back at the witness table. Whilst listening to P118's sister give evidence, there were two other matters that P118's mother remembered that she would particularly like to bring to the Panel's attention.
CHAIRPERSON: Absolutely, okay.

16:12

P118's MOTHER GAVE FURTHER EVIDENCE AS FOLLOWS TO THE INQUIRY:

16:12

165 Q. MS. KILEY: So P118's mother, as you know, we are going to refer to your son as P118, or your son, and is it right that in listening to your daughter give evidence there were two matters that you wanted to raise with the Panel?

16:12

A. Yes.

166 Q. And the first was in relation to the incident that you have already described at paragraph 37 of your statement, isn't that right?

16:13

A. Yes.

167 Q. You have that in front of you. This relates to the time where in and around 2014 and 2015, your son was in

Antrim Hospital and at paragraph 37 there you have already said that whenever your son was discharged from Antrim Hospital you requested an interview with Dr. H40, your son's consultant?

A. That's correct.

168 Q. In listening to your daughter give evidence, there was something else that you remembered about that. Do you want to tell the Panel what that was?

A. Yeah, I brought it to the attention of H40 on that interview that Muckamore Abbey Hospital didn't have medical cover at night, which I thought it was appalling. 16:13

169 Q. What do you mean by "medical cover"?

A. A doctor. And one of the reasons why my son wasn't admitted to Antrim Area Hospital until the morning of the evening that he took ill, was very ill with the inflammatory situation with swallowing the batteries was because there wasn't a doctor there to see him until the morning. 16:14

170 Q. That was on the separate occasion that you have referred to in your statement? 16:14

A. Yes. H40's reply to that was that there was an ongoing meeting, he said, and one coming up very soon which he invited me to attend which they were going to discuss that they would bring that forward in terms of having a medical officer on Board, certainly in the evenings. I didn't attend that meeting because it wasn't suitable for me on the day, because I still work, and so I didn't get to hear the whole layout of that, but about 16:14

three months later I was aware at visiting time that a locum doctor was on duty from eight o'clock to eleven and I was then told that that was in situ.

171 Q. So there was then medical cover from eight o'clock?

A. From eight o'clock to 11:00 when patients who were displaying some sort of illness, that that doctor was there, he just stayed in a room off the reception area and the patients would have been brought from any of the wards, but it was based in Cranfield 1. 16:15

172 Q. Okay. And to your knowledge that was ...(interjection)? 16:16

173 Q. DR. MAXWELL: Can I just clarify you are talking about resident medical cover? There would have been medical cover off site that the nurses could call but you're talking about resident medical cover? 16:16

A. Yes.

174 Q. MS. KILEY: The second issue then that you wanted to reply to was the Chair's question to your daughter about resettlement of your son and in exchanges, there was a discussion about how long it took for your son to move out of Muckamore and I know you wanted to say something about that? 16:16

A. Yeah, yeah. Well, they did have and did hold and I attended every one of those progress meetings that they called and there would have been maybe 12 people from the Trust, ward staff, the consultant as well, and at every progress meeting, all we heard was that there was no finance available to resettle [name's son]. 16:16

175 Q. So you were telling me there that you attended all the

progress meetings in relation to proposed resettlement and you were about to tell me something about what was discussed about finance?

A. Yes, finance seem to be a big problem until Stephen Nolan from BBC decided he was going in and made an issue out of the -- because it had been brought to his attention that there were numerous patients in there who had been there for many, many, many, many years, a lot of them died in there as well. So at that time, H40 told me that money had been thrown at them, and that's the words he used to me, thrown at them to get patients out of Muckamore Abbey Hospital. 16:17 16:18

176 Q. What time period would that have been?

A. Year?

177 Q. Yes, if you can, roughly. 16:18

A. That was probably three or four years before [name's son]'s discharge.

178 Q. Okay, so I just asked you to clarify the time period for that, and you are telling me it was three or four years before your son's discharge, is that right? 16:18

A. Discharge, yes.

179 Q. And are those all the issues that you wanted to raise with the Panel, the additional issue that came to you when listening to the evidence?

A. Yeah, with Muckamore Abbey Hospital anyway, yes. 16:19

CHAIRPERSON: Okay. Well, again thank you for coming back and thank you for giving us that additional information. Thank you both again and you can now go with Jaclyn, that completes your evidence to the

Inquiry.

A. Thank you. Could I just take this opportunity not only on behalf of ourselves, as my son's family, to thank everyone involved in this Inquiry. It's meant so much to so many people and also to people whose relatives who have passed away, whose relatives are passed away too, and I have to say that just a few months before it all was exposed, certainly on the BBC, I actually one day, and I have to tell you all this, one day I was coming away from visiting my son from that hospital and on the way past the main offices, I said a prayer and I said: "Lord, I would love that this was exposed, what goes on in this institution here." And the evening -- I just happened to be in my kitchen when it came on the BBC about the Inquiry and tears were literally running down my face, because I felt that prayer was answered. Yes. So it's....

CHAIRPERSON: Well, thank you.

A. So I just wanted to say thank you for listening because that has been so important to everybody, to all families.

CHAIRPERSON: Well, thank you very much indeed for those kind words and we hope that at least some of your prayers are answered, all right.

A. Thank you.

THE WITNESS THE WITHDREW.

MS. KILEY: Chair, the next witness is here and is

ready to proceed, Mr. McEvoy is taking that evidence.
CHAIRPERSON: Okay. Where is Mr. McEvoy?
MS. KILEY: He's just outside.
CHAIRPERSON: Right, lets get him in. I'm not going to rise as it will take another minutes so we will wait. 16:21

Mr. McEvoy, welcome back to the hot seat, as it were. Are you ready for the next witness?
MR. MCEVOY: Certainly are, Chair.
16:22

P8'S MOTHER HAVING BEEN SWORN WAS EXAMINED BY MR MCEVOY AS FOLLOWS:

CHAIRPERSON: If we can just identify who we have got in the witness box. 16:22
MR. MCEVOY: So Chair/Panel this afternoon, the final witness the Inquiry will hear from, is mother from P8. The Inquiry heard P8's mother's statement on the 26th of September when I read it into the record and the Inquiry and Core Participants will recall that P8's 16:22 mother was unwell and unavailable through illness on that occasion and she is now....
CHAIRPERSON: Yes, what we wanted to do -- I am going to call you P8's mother, I'm afraid, is to give you the opportunity of saying really anything that you wanted 16:23 to, but you know that your evidence has been read in. Were you well enough to watch that or not?
A. No.
180 Q. CHAIRPERSON: No. But you know your statement, of

course.

A. Yeah.

CHAIRPERSON: All right. Well, I will hand you over.

MR. MCEVOY: P8's mother, welcome along and there are may be a few matters that you can clarify arising from your statement. As you know, it has been read in. The first of those relates to what you have told the Inquiry in your statement at paragraph 26 and hopefully, we will help you find it. I'll check on this point, in this paragraph you tell us about a meeting up at Muckamore on 23rd of June 2012 and if you recall the circumstances of it, it was a visit in fact with your son, you weren't allowed to take him to the Cosy Corner on that occasion and you described then being "herded like cattle" into a small visitor's room and treated like criminals, you felt, not allowed to open the window, the blinds or the door and you were told that the reason for that was you were not allowed, the background to it that there had been an issue between your son and another patient. No eye contact was allowed and you didn't know the nature of the allegation. You said the room was very stuffy and there were about nine people in it. Now the simple point to be clarified there is can you remember, is that the right number of people who were in the room? 16:23 16:24 16:24 16:24 16:25

A. No, seven.

181 Q. Thank you.

CHAIRPERSON: Because that is what was said in the exhibit, I remember this. Thank you.

MR. MCEVOY: Yes. A small but no doubt important point and the Inquiry likes to be accurate about everything. And on that same score then, in terms of accuracy, turning to paragraph 38 which is on page 15. Just to set this particular topic in context here, you talk about, and we will come back to it in a moment, the Mental Health Review Tribunals and your efforts to get representation and assistance in order to get your son's detention examined by the Review Tribunal. At paragraph 38 you say that: 16:25 16:25

"None of the staff in Muckamore advised me of the advocacy service available to parents and families offered by Bryson House. I only became aware of this by speaking with another patient's mother in the Cosy Corner at some stage..." 16:26

And you say in your statement: "...during 2016." Is there any correction you want to make to that?

A. Yeah, it should have been 2015. 16:26

182 Q. Okay. Well, thank you.

A. Thank you.

183 Q. So I just have a very small number of questions arising out of what is a very comprehensive and helpful statement. Turning to page 23, I'm not going to take you through this document, which is about five pages in length, but turning to page 23 is a letter dated the 16th of August 2012. Okay, you have that in front of you all right? 16:26

A. Yep.

184 Q. And it's a letter to Mr. Convery at the Mental Health and Learning Disability Team in the RQIA. And in that letter then, and over the following pages, you set out all of the issues that you were experiencing. Did you write that letter yourself or did you have any assistance? 16:27

A. No, I wrote that myself. My sister helped me type it up but I wrote it out to them.

185 Q. Okay. And then there is a response, turning to page 41, dated the 28th of August 2012 and it's from Teresa Nixon, who is the Director of Mental Health and Learning Disability and Social Work at the RQIA. She says: 16:27

"I am concerned about the serious matters you raised in your correspondence. RQIA have written to the Chief Executive of the Belfast Trust seeking clarification in respect of a number of matters and assurance about the actions the Trust in relation to the safeguarding and protection of your son and other residents as referred to in your letter. I wish to assure you that the RQIA will follow up with the serious matters you have brought to our attention as matter of priority." 16:27

16:28

And you are given a contact as well. So that was the 28th August 2012. Did you hear from the RQIA after that?

A. Not after that, no.

186 Q. No?
A. No.
187 Q. Finally then, just on the question of -- so we touched on a moment ago the Mental Health Review Tribunal, there were two attempts, as you describe in your statement, to get your son out of the detention, the first was in 2013? 16:28
A. Yeah.
188 Q. Had you any assistance of any description during 2013 effort to help you with representation to the Mental Health Review Tribunal? 16:28
A. I had a solicitor. A solicitor with me, yep, that was it.
189 Q. Okay. And no other form of advocacy or any input like that? 16:29
A. No, I didn't. No.
190 Q. Okay, and then in 2015 can you tell us about any change in the interim?
A. Yes, I had, as I stated on my thing, Bryson House.
191 Q. Yes. 16:29
A. And that opened doors.
192 Q. Okay. And can you tell us a bit more about that?
A. He explained the whole situation about the tribunal and where it goes from start to finish, what evidence I needed, you know, put me through the whole -- and made me more relaxed, you know, took word for word for everything like, you know, he got me where I am today, do you know, my son out. 16:29
193 Q. Yes. And having access to that type of advocacy

service, we can take it was important in that process and what would you say about your experience perhaps for others in a similar position to you as a mother with a patient in Muckamore?

A. They should be informed of your loved ones going in, do you know what, who is there for help, who can guide you through it, who can give you advice. 16:29

194 Q. You have described in your evidence, you have described it in your evidence, it was sheer luck?

A. Yep, that I was talking to that mother, yep. 16:30

195 Q. I mean, in your view as a mother, clearly I think I know what the answer to this question might be, but is that an acceptable way to communicate?

A. No.

196 Q. All right. And then just in terms of the process itself around the Mental Health Review Tribunal, you've included some documents. One of those is a report from one of the psychiatrists, who is H50, and if you can find that at page 58. Okay. So it's really just so that everybody else knows what document I am talking about, but this is a medical report that was prepared in relation to your son by the Clinical Director, who has described himself as the Designated Risk Manager. During that process, running up to the Mental Health Review Tribunal, were you consulted with -- did the Clinical Director or any other psychiatrists or the clinical team speak to you about what they might be putting into their report? 16:30 16:31 16:31

A. No, no, I just learned on the day.

197 Q. Well, that was my next question; what kind of notice did you get?
A. Just learned on the day.
198 Q. Of that report and what it said in it?
A. No, I just learned what was all said on the day. I was given your date, and, do you know, that's all. 16:31
199 Q. Yes. So you got notice of when the review tribunal was going to take place?
A. Yes.
200 Q. But you didn't actually get sight of the report until the day? 16:31
A. Didn't hear anything until the day, until I was in the room.
201 Q. And therefore, there was no opportunity to get a second opinion or anything of what was in the report? 16:32
A. No.
202 Q. All right. That's very helpful. Can I just ask you how your son is getting on now? I know you tell us in the statement but it's always nice to hear first-hand?
A. Yes, he is doing well, a bit of health issues, but he's getting on, he's blooming. 16:32
203 Q. He has been out since 2017 and he is at home with you?
A. He is indeed.
204 Q. And it's working well?
A. Yes. 16:32
205 Q. Those are my questions, P8's Mother.
A. Thank you very much.
206 Q. There maybe something from the Panel, thank you.

P8'S MOTHER WAS QUESTIONED BY THE PANEL AS FOLLOWS:

207 Q. CHAIRPERSON: No, I have only got one thing; the letter that you were referred to, to the RQIA of the 16th of August, and you have got that at page 23, that's a five page or a six page letter and do you remember you set out a series of concerns that you had in that letter and then you got a response on the 28th August and are you saying that's the only response you got? 16:32 16:33

A. Yep.

208 Q. CHAIRPERSON: Did you follow it up.

A. I did, I asked when I went up to visit, I visited my son three/four times a week and I kept asking was there any, because I knew that [name's son] had told me. 16:33

CHAIRPERSON: Okay, we're just going to pause for a second, you've done very well so far. Yes.

A. After my son informed me that RQIA was in the building and I had asked them, I knew that RQIA had visited the ward so I started asking was there any reports, was there any...? 16:33

209 Q. CHAIRPERSON: Sure, but you didn't follow up with the RQIA?

A. No. No.

210 Q. CHAIRPERSON: And you didn't get anything else from the RQIA? 16:33

A. No, just that letter to say that they received my letter.

CHAIRPERSON: Thank you very much indeed. Thank you

for coming back. Thank you for making your original statement. I'm sorry you weren't well enough to come and assist us on the day but I'm glad you have had the opportunity now to adding those couple of clarifications. 16:34

A. Thank you for closure. Thank you very much.

CHAIRPERSON: I understand. Anything else?

MR. MCEVOY: No, just my directions in relation to tomorrow.

CHAIRPERSON: Right, thank you very much if you would like to go with the secretary to the Inquiry. 16:34

THE WITNESS THEN WITHDREW

CHAIRPERSON: Tomorrow, we're not attempting a 9.30 start, are we? 16:34

MR. MCEVOY: I think that's right.

CHAIRPERSON: We are or we're not?

MR. MCEVOY: Are we?

CHAIRPERSON: My understanding is tomorrow we are 10 o'clock. 16:34

MR. MCEVOY: 10 o'clock.

CHAIRPERSON: I will just check with the Secretary to the Inquiry. Jaclyn, tomorrow we are 10 o'clock?

MS. RICHARDSON: Yes. 16:34

CHAIRPERSON: Okay.

MR. MCEVOY: I am the late shift again tomorrow.

CHAIRPERSON: We will try and sit at 10, I do apologise again for getting everybody here at half past nine.

My frustration, I assure you, is as great as yours. All right, thank you very much indeed, see everybody tomorrow at 10 o'clock.

THE HEARING ADJOURNED UNTIL TUESDAY, 10TH OCTOBER AT 10.00 A.M. 16:35