MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON THURSDAY, 28TH SEPTEMBER 2023 - DAY 63

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WITNESS PAGE

THE INQUIRY RESUMED ON THURSDAY, 28TH SEPTEMBER 2023 AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you. Right, just take a seat for a moment, Ms. Tang. Sorry. I gather there are Box issues, or there had been Box issues this morning. I think it's up and running now, but we'll just have to see how that goes, but I gather that we can put those parts of the statement that we want to up on the screen. 10:00

I just want to make a few comments about the evidence yesterday afternoon. We all understand how difficult it is to give evidence about the mis-treatment of a loved one, and motions are bound to run high and come to the surface when giving evidence. However, even taking that into account, the Panel feels that the use of adjectives such as "evil", if applied to any individual using the protection of the public Inquiry to do so, is wholly inappropriate. And I want to give this assurance to any future potential witness. We, as a Panel, listen objectively to the evidence which comes before us. We are not at this stage making our minds up about anything, and we recognise that there are always different sides to events and different versions of events to give, and we will continue to listen carefully and objectively to all accounts given to us. 10:01 10:01 10:01

I do expect going forward that people will bear in mind

that this is a public forum and that the language used should reflect that. All right. Ms. Tang, we've got quite a full day. It's all I think mostly evidence that's going to be read, and we're starting with P119's mother.

MS. TANG: Yes, that's correct, Chair.

CHAIRPERSON: And is there a Restriction Order application?

MS. TANG: Yes, there is, Chair. This morning I am going to be reading three statements, and we will be following that at 1:30pm with the evidence of P110's mother's who will be joining us by Zoom.

In relation to the Restriction Orders, there will be an application for a Restriction Order for elements of P119's mother's evidence, and an application for a full Restriction Order for the entirety of P122's statement. And there's no application to make in respect of the statement of P123's sister.

CHAIRPERSON: Well, let's deal with them in turn. P119's mother first of all. Do you just want to indicate which paragraphs I need to look at and what the basis of the Order is?

MS. TANG: I will, Chair. I should say that...

CHAIRPERSON: Sorry, before we do that, because you are about to make an application, I'll place a Restriction Order in relation to the application itself to ensure that if I do make the Order that it is effective. Yes, sorry Ms. Tang.

MS. TANG: Thank you, Chair. Yes. In relation to P119's mother's statement. P119's mother has indicated that she is content for her name and her daughter's name to be read and when reading the statement...

CHAIRPERSON: To be used you mean. Yeah, yeah. Yeah. 10:03

MS. TANG: To be used, yes. And in reading the statement I will therefore follow our usual practice of referring to the patient and the patient's mother by their first names.

CHAIRPERSON: Right. 10:04

MS. TANG: The application for a Restriction Order is made by PSNI and the PPS, and the application relates to the following paragraphs. Paragraphs 36 to 41.

CHAIRPERSON: Hold on a second, sorry. Yep.

MS. TANG: And the PPS have focused specifically on 10:04 paragraph 39. The PSNI have explained the basis of the application as follows: They've identified that there are - that there is an ongoing criminal investigation into matters relating to P119's mother's evidence. This application is made with reference to the MOU 10:04 which exists in relation to...

CHAIRPERSON: Yes. I mean having looked briefly at those paragraphs it is quite obvious why the PSNI have their sensitivities.

MS. TANG: Thank you. Well the Inquiry Counsel have 10:04 considered the matter and we would agree with the imposition of a Restriction Order.

CHAIRPERSON: So it's just those paragraphs?

MS. TANG: Yes. That's correct, Chair.

CHAIRPERSON: What about the use of the names? There's no difficulty about those being made public, or is there?

MS. TANG: In relation to the open elements of it, the names, the first names are acceptable at this point. But in the closed session, not. 10:05

CHAIRPERSON: No, no, of course not.

MS. TANG: And there would be a Restriction Order, and we would ask that a Restriction Order be imposed on the reporting of those names. 10:05

CHAIRPERSON: Ah! So. Right.

MS. TANG: Yes.

CHAIRPERSON: So you do want a Restriction Order in relation to the names that are going to be used?

MS. TANG: Yes. Yes. 10:05

CHAIRPERSON: But that's not what we've referred to as a full Restriction Order?

MS. TANG: Yes.

CHAIRPERSON: So Room B can remain, the feed to Room B can remain open. And I can understand the sensitivities around the use of the names being made public, because they would potentially be readily identifiable in criminal proceedings. All right. So, obviously the order will have to be formally drawn up, but I will make a Restriction Order in relation to the publication by anybody of the use of the two names, which are P119 and P119's mother. Yes? 10:05

MS. TANG: P119 and P119's mother. Yes. P119's mother is the mother.

CHAIRPERSON: Yes. And I will order that there is a full, what is termed a full Restriction Order in relation to paragraphs 36 to 41, which you will deal with separately in any event.

MS. TANG: Yes. 10:06

CHAIRPERSON: And for those, the feed to Room B will have to be closed.

MS. TANG: Yes. Thank you.

CHAIRPERSON: Okay. Thank you very much indeed.

MS. TANG: Chair, if I could turn also to P122's 10:06 statement in relation to Restriction Order.

CHAIRPERSON: Yes. Sure.

MS. TANG: The application - I would seek to make an application for that also, and it's made at the request of the patient's legal representatives, Phoenix Law, on 10:06 the basis of the patient's own concerns. He remains a patient in MAH and is concerned that if the fact that he has made a statement were revealed, this could negatively effect his situation. So Inquiry Counsel have considered that matter and agree that an 10:07 imposition of a Restriction Order of that kind is necessary in the public interests and having regard to the individual's status as a patient and has specific concerns about his identity becoming known.

CHAIRPERSON: Certainly. Again, can I cut you short? 10:07 I've been aware of the sensitivities around this patient for some time. I'm not surprised an application is being made, and I think it's absolutely right to protect that person's identity completely. I

will make a full Restriction Order in relation to the reading of that statement.

MS. TANG: Thank you, Chair.

CHAIRPERSON: So that will mean that the feed has to be cut. 10:07

MS. TANG: Yes. Thank you.

CHAIRPERSON: All right.

MS. TANG: Thank you. I am going to proceed then to read the elements of P119's mother's statement which are not subject to the Restriction Order, and then I'll 10:07 pause at that point and move on to the elements that are.

CHAIRPERSON: Sure. Thank you very much.

MS. TANG: Okay. The statement is P119's mother. The page reference is 164-1. The statement is dated 20th 10:08 day of September 2023.

P119'S MOTHER'S STATEMENT READ:

MS. TANG: 10:08

"I, P119's mother, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry.

My connection with MAH is that my daughter P119 was a 10:08 patient at MAH. The relevant time that I can speak about is between 2012 and 2020.

I am the mother of P119, who is my eldest child and

first born. P119 and I are very close. I have two other children. P119 was born in May 1987 and is now 35 years old. P119 is a much loved member of our family. She has a very close wider family circle.

10:08

My daughter is currently registered as the person to contact in an emergency if I cannot be reached.

P119 has a great personality. In her younger years she refused to talk but enjoyed slapstick humour. P119 is 10:09
a huge fan of Mr. Bean and loved to be involved in practical jokes on others. She saw the funny side of things and enjoys life.

Currently P119 has several invisible friends. When I 10:09
visited P119 recently I asked her what they looked like she answered "Mum, don't be silly they're invisible."

P119 remains very much childlike. Not only does she have invisible friends but she also has dolls, and her 10:09
life-long comfort companion is Emma, who looks like Minnie Mouse, but to P119 she is her closest friend. She also has a dog called Cassie, who lives with me and is brought to visits.

10:09

In or around 1991, when P119 was about four years old, she was diagnosed as mentally retarded at an assessment clinic within Musgrave Park Hospital. The reason for the assessment was because P119 did not speak and I

thought that she might be deaf. P119 was happy in the community. She attended school in Dundonald aged four years and made very good friends with a girl who went there. Unfortunately that child died in hospital and P119 did not seem to develop any comparable friendships since. P119 still remembers her friend and speaks of her.

From around 2006, when P119 was about 19 years old, she started to go for short periods of respite care to a facility in Knocknagoney. This was the first time P119 had been away from home. 10:10

In or about 2008 my mother suffered a stroke and I took on increased visiting. By 2010 I found it difficult to manage with my increasing responsibilities for my mother and P119's behaviour at home, which was deteriorating. 10:10

P119's behaviour was challenging and would include, hitting, striking out at me, auditory and visual hallucinations, smearing faeces on her bedroom wall and incontinence issues. I struggled with the lack of support for P119 in the community during these times and had no choice but to get P119 the specialist support she needed. 10:10 10:11

In 2010, in response to the difficult circumstances at home, P119 was placed in a supported living placement

in Belfast. P119 was about 23 years old at the time. This was the first time that P119 had lived for any significant period away from home. It was heartbreaking for me to have to put P119 into a care setting.

P119 was initially happy there, but her behaviour deteriorated. She wrecked property in the facility a few times. At times P119 would also leave the facility. This was potentially dangerous as P119 had no sense of danger and ran out onto the road on at least four occasions. It became clear that it was not safe for her to remain in that facility if her behaviour continued in that way.

In 2012, P119 was admitted to MAH for a brief period for the purposes of an assessment and an examination of her medication, following which she returned to the Belfast placement.

In 2013, when P119 was about 26 years old, her placement broke down. The facility reported that P119's behaviour had become increasingly erratic and dangerous both for her and others around her. P119 started having pseudoseizures.

I received a telephone call late one evening to be advised that P119 was being taken to MAH as an emergency due to a deterioration in her behaviour. I

accompanied P119 in an ambulance to MAH. I believed P119 would be there for a short period to assess her, provide a diagnosis, and to identify appropriate medication and a plan for her, the same as what had happened when she was admitted in 2012. I genuinely believed that this would get my daughter the right care so that she could have a better life. I entrusted the care of my daughter to them. Above all, I trusted the staff at MAH to take care of P119. 10:12

P119 was detained under the Mental Health Order and admitted to MAH to Cranfield Women's Ward. P119 remained a detained patient throughout her stay at MAH. I did not at first appreciate exactly what this meant and do not recall being informed what detention under the Mental Health Order meant. 10:13

There were Mental Health Review Tribunals each year during P119's stay, but I do not recall being invited to these. I do accept that it is likely I was invited, but they seemed more of a rubber stamp exercise. I now know how important they are. 10:13

P119's mental health deteriorated during her stay in MAH. At times P119 was moved into the Adult Psychiatric Intensive Care Unit (PICU) for a period, and then moved back to the main Cranfield Women's Ward. I was not provided with any literature about PICU or MAH in general setting out principles, policies, 10:13

procedures or patient's rights.

When I went to MAH to visit P119, the staff were friendly, and I assumed they were doing their best for P119. I felt that they had taken on my role and were providing primary care to P119. I did not suspect that P119 could be coming to any harm. 10:14

I did notice that there seemed to be many incidents which would result in P119 sustaining injury. She had bruises to her arms, her legs, and sometimes on her face. These were explained by the staff as P119's clumsiness or evidence of her frustration. I now do not accept this. 10:14

A specific example of this is when I was told that P119 had broken her big toe on her right foot in August 2014. An intraarticular fracture distal end of the right great toe was identified when P119 was taken to Antrim Area Hospital. Staff advised me that P119 had broken her toe kicking a door and that this was a self-inflicted injury. There was no real further explanation about how it happened. I was surprised that she had been able to injure herself to that extent, and whilst I knew that P119 could sometimes throw herself down on the floor, I had never been informed about such an injury being sustained in that way before. I took the staff at their word as it did not occur to me that staff in MAH could cause P119 10:14 10:15

harm.

Upon reflection, I realise just how trusting and accepting I was. I deeply regret not questioning staff more and just taking their word for things, for believing that I had left P119 with people who would care for her properly. 10:15

I was never allowed to see P119's bedroom when she was in Cranfield. Like any mother would, I wanted to see how P119 was living and how I could brighten it up for her. It was explained that only staff were allowed on the wards. I accepted that, but did not imagine that the walls of what was effectively P119's home for many years would be so bear and that there would be so little done to personalise it for her. 10:15 10:15

I was concerned about the deterioration in P119's appearance. She was often untidy and unkempt. Sometimes P119's clothes were not put on her properly. This would have been the responsibility of the staff, as P119 required help with her personal hygiene and dressing. P119 looked like she had been thrown together. Whilst some staff helped to tidy her hair, others did not, and it pained me to see P119 looking such a mess. 10:16 10:16

Our family would purchase some clothing for P119 as presents, but MAH and Belfast Health and Social Care

Trust received and managed P119's benefits, which they were supposed to use to purchase all her clothing and other necessities for her.

Around Christmas time in 2017, I requested £500 so that we could take P119 out and buy her some proper clothes. Despite this, we often wondered what happened to the clothes we bought for P119, as we rarely saw her wearing them. 10:16

During the day P119 went to a day centre and did painting or colouring in. She seemed happy enough at the day centre, but this only took place between 1:00pm and 4:00pm, and I did not know if there were any activities for her during the rest of the day or what else she did when we were not visiting. 10:17

She did not seem to have any friends. I think that was difficult for her and she may have been lonely.

I met my husband Paul in 2014. He is a trained learning disability nurse. We visited P119 together and P119 and Paul got on well. P119 even advised me once "Paul's a good husband, keep hold of him." Paul also noticed the changes in P119 over time. 10:17

P119 was diagnosed with schizophrenia whilst at MAH. I do not know the exact date of this diagnosis, although it should be reflected in her medical notes. P119 also

has a history of neuroleptic malignant syndrome. This condition is a life-threatening reaction to the use of anti-psychotic type medication, which P119 was being prescribed in MAH. I believe that medication to be known as Clozapine, which was prescribed to P119 in 2015 for management of her diagnosed schizoaffective disorder. 10:18

During this adverse reaction P119 experienced nausea, high temperature, tremors, and was ultimately admitted to Antrim Area Hospital and treated for toxic impact. 10:18

During a review meeting in early 2016, I was informed for the first time that P119 had a diagnosis of autism. This only came to light after prompting from my husband Paul to gain an insight into the treatment that P119 was receiving whilst at MAH. Paul was more suspicious of the MAH regime, however I was more accepting, not wanting to complain, and believing that everyone at MAH were supporting P119 as best they could. 10:18

Later in 2016, Paul and I were invited to attend a Mental Health Review Tribunal (MHRT) at MAH. I remember going to the meeting with optimism. Paul wanted to pursue having P119 for an overnight visit, maybe even taking her on a short holiday. We were not brought into the MHRT and our views were not taken. I left crying, with feelings that my role as a mother had been taken away by MAH. 10:19

In or around late 2016 early 2017, we were contacted by P119's consultant because he wanted to treat P119 with a series of electroconvulsive therapy or ECT sessions. It was explained to us that this would re-start her and that it may help to improve her mood.

The proposed treatment of ECT was before we knew about the abuse that P119 had suffered. When I look back now at the decision to treat P119 with ECT, I question the true need for this treatment.

I am concerned that P119's behaviour which MAH sought to treat with ECT may have been a reaction to the neglect and abuse she suffered at the hands of MAH staff.

With my husband's knowledge as a learning disability nurse, I now know that ECT is an extreme treatment and should be considered as a treatment of last resort.

Looking book on this period, in the light of the knowledge I now have about P119's abusive, I have very serious concerns about whether P119 required this treatment at all.

After the sessions of ECT, P119's mobility was impacted. Prior to the treatment P119 had a normal walking pattern, however, since then she has been

clumsier. For example, when Paul and I used to visit MAH we would bring our dog and run around chasing the dog with P119. P119 was unable to engage in this activity after the ECT. P119 now takes more of a cautious step pattern rather than a free-flowing walk. 10:20

In or around April/May 2017, Paul and I took P119 out of MAH for lunch in Antrim town centre. We regularly took P119 to a fish and chip shop there as the staff were great with P119. On that occasion it was quite 10:20 warm, and when we got into the chip shop I asked P119 to take her coat off. P119 was wearing a short sleeved blouse and it could clearly be seen that P119 was covered in large bruises. When we brought P119 back to MAH and asked the nurses about the bruises, staff 10:21 advised that they were from P119 throwing herself onto the ground and were self-inflicted. At the time I believed this explanation but I now do not accept it. I asked why I was not informed and the staff apologised for not updating me. 10:21

In the summer of 2017, P119 was relocated from Cranfield to Donegore Ward. I was given little information about the reason for or purpose of the relocation. The staff in Donegore seemed nice and 10:21 pleasant. P119's behaviour and moods appeared to improve, her presentation had greatly improved and we were finally permitted to see her bedroom.

I got to see P119's bedroom once at Donegore. It was nice enough, but bare. I noticed that lots of items, such as photographs that I had given her over the years, were not there. I provided P119 with lots of photographs of the family to make her room homely. We had been careful to remove any glass from the photo frame and have perspex covers inserted instead. I was gobsmacked when I visited P119's bedroom and realised how impersonal it was and that P119 had one photograph of her sister and one of our dog. 10:22

I recall a visit with P119 after she had moved from Cranfield to Donegore. We brought the dog with us and had taken P119 outside for some fresh air. The dog took us to the rear of Cranfield, and when P119 saw the back of Cranfield her whole mood changed. She became anxious, agitated, and wanted to get away from Cranfield. We had to take her straight back to her new unit in Donegore. P119 herself requested her PRN medication to settle down. Even the very sight of Cranfield traumatised P119." 10:22

I'm going to move on now to paragraph 42:

"I have a family liaison officer from the PSNI, but I have not heard from her recently. This is at my own request as I severely struggled to deal with the realisation of what has happened. 10:23

After I found out about the abuse, there was a meeting which took place just opposite Donegore Ward. Another patient's father was there, and there were some other parents of patients there too. There was a discussion about how the abuse was unacceptable. So far as I was concerned there was no communication about the investigation into the abuse, and I was not asked to participate in anything to do with it. 10:23

I was very concerned about whether individual staff members who had abused P119 were still working at MAH, as at this stage P119 was still living there. I found it difficult to get answers to where the responsible staff were. 10:23

I continued to visit P119 at MAH as often as I could. Each visit was heart-wrenching, because at the end of each visit I had to leave her there. 10:23

I am P119's mother, but as years passed by, my opinions and involvement in P119's care became of less relevance to MAH. I began to feel that I did not matter. 10:24

I never got to see how she lived, even though she was there for around six years. I felt I was having my rights as a mother gradually taken away from me, especially as I am quiet and have a non-suspicious accepting nature. MAH staff took advantage of that. 10:24

When I realised that P119 had potentially been subjected to abuse in MAH since 2010, I wanted her out of there as quickly as possible, but even this became a nightmare.

10:24

At the beginning of the Covid-19 pandemic, my husband Paul and I were telephoned by P119's consultant, Dr. H223. He asked us to agree to a DNR should P119 contract Covid-19 and end up on a ventilator in hospital. I refused to agree to this. P119 was a healthy young woman and I had not been provided with any reason to believe that a ventilator would ever be required or that it should be switched off.

10:24

I was shocked and could not believe that I was being asked to agree to this. The only apparent reason for this was that P119 had a learning disability and the value of an individual with a learning disability in MAH was not equal to those in the general community.

10:25

My husband Paul and I tried to visit as often as we could to take P119 for a walk around the grounds. Sometimes when we telephoned in advance of a visit we were told that P119 was not having a good day and that we would not be able to see her. Even if we were ever able to speak to P119 on the telephone, there was always a nurse in the background and we never got any privacy during telephone calls.

10:25

I did not make any formal complaints during P119's time at MAH. I bitterly regret that now.

In or around January 2020, my husband Paul and I were invited to a meeting about P119's resettlement. There had been some earlier meetings about it in the MAH administration building. I did not know why resettlement was taking so long and assumed that the meeting was being called to explain the progress. 10:25

10:26

Paul, in his role as a learning disability nurse was accustomed to such meetings, and tried to prepare me for what to expect. I was not emotionally ready for what I walked into, which turned out to be a multidisciplinary team meeting. 10:26

We were met in a room with around eight to ten professionals consisting of social workers, occupational therapists, consultants, etc.. They were wanting to move P119 to a house across the road from MAH to a bungalow. Paul and I live in Belfast and had always wanted her resettlement to be near us so that we could visit her more frequently. 10:26

I broke down crying at the meeting and had to walk out once they mentioned moving P119 to a bungalow across the road from MAH, which was located next to a main road. 10:26

The lack of empathy and understanding from those to whom I had entrusted the care of my daughter was just too much for me. They still smiled and acted like they were suggesting that this was in P119's best interest.

10:27

When I returned to the meeting, the person in charge of P119's resettlement continued to ask me if I wanted to see the new proposed accommodation, oblivious to my distress.

10:27

Paul took over from me at the meeting as I was so upset. Paul left the meeting in absolutely no doubt that we would no longer be soft touches for them.

We did not ask for P119 to be moved back to Belfast, rather we made it very very clear that P119 needed to be back in Belfast without delay. 10:27

P119 returned to Belfast as the first resident at a new specialised learning disability home in August 2020. 10:27

During P119's entire time at MAH, I only ever saw a care plan at her resettlement meeting. I did not see one before this point and I do not even know one existed. There was very little documentation provided to me about P119's treatment and care whilst she was at MAH. 10:28

Prior to P119's discharge from MAH, a comprehensive

needs assessment was compiled to support P119's transition to her new home, which made assertions around P119's needs.

Since moving to her new home, P119 continues to have pseudoseizures, and upon asking staff at the home what happens, they claim that P119's actions during these events appear entirely deliberate and she would be fully aware of her surroundings. For example, she would put herself onto the ground, she may even move around and throw her arms, legs, but never ends up with significant bruising. Staff describe it as deliberate and controlled motions. 10:28 10:28

They report that there maybe incidents whereby P119 will bang into a wall, but again they say this is typically a controlled and deliberate motion that P119 will do for attention and rarely causes herself an injury. 10:28

Since P119 was resettled her whole mood and behaviour initially improved. This was achieved without any change in her medication. P119 now has her own mobile phone. I can telephone her directly now. 10:29

P119 was not allowed a mobile at MAH throughout her stay there. We were told that this was because of the wi-fi.

P119 was not allowed a tablet. I asked for P119 to have a tablet so that she could watch cartoons in her own space, but I was told that she could not have one, and was given the explanation that it was because of confidentiality. 10:29

I was told that if P119 wanted to watch some television then she could do that in the day room. I understand that there always other patients in there and that there would be arguments about who would get to choose 10:29 what to watch and that this would potentially trigger behaviours from P119.

In her resettled facility P119 has a television in her bedroom as well as one in the lounge. She even has her 10:29 own back garden. We are permitted to take P119 out for a meal, and P119's sister and partner recently took her out for a burger and a drive around town.

In 2021, after 10 years away from home, P119 got to 10:30 come home and stay overnight for Christmas, have Christmas dinner with her family and open her presents. I finally got to feel a little more like a mum again when I visited P119. I even gave her a bath and did her hair. There was only a small matter of having to 10:30 watch non-stop Mr. Bean, but P119 loved it.

P119 had a horrendous experience in MAH and I feel the responsibility for that every single day as I was the

one who left P119 there and who was fooled by the staff at all levels that P119 was being properly treated and getting the care that she needed.

Throughout her life since the age of four, and even through her stay at MAH, P119 has always loved being part of her community and engaging with her peers in a supervised structured external day care placement. It gave her a sense of purpose, something she looked forward to. Though she did not develop significant friendships, she would have engagement with her peer group and really enjoyed that companionship. She would gossip with me on the telephone about what so and so did and tell me about how her companions were doing. It gave her a sense of belonging and purpose and a structure to her daily/weekly routine. 10:30 10:31 10:31

Having an external day care placement in place was an integral and significant part of P119 having a successful transition to her new community placement. Since transitioning to her new placement, P119 never had an external day care placement implemented. She no longer had that feeling of being part of her community. 10:31

The staff, I can only thank for the support they gave P119 during this period. They went above and beyond, but they should never have had to deal with or experience the behaviour that P119 presented with if the BHSCT had implemented what was agreed in terms of 10:31

an external daycare placement.

During the period during July to August 2022, P119 suffered a significant deterioration in her mental health and general behaviour. P119 began to display some extreme self-harm and suicidal behaviours. She began to speak a lot more about her childhood friend who passed away many years before. She would even refer to her comfort companion, her doll "Emma" as being dead, and that she herself was wanting to die to be with them. 10:32 10:32

P119 was suicidal and wanted to die to be back with her friend. I believe this was due to her virtual exclusion from her peer group and the failure to provide that continuity of care and provide the agreed external day care placement that had allowed P119 to always feel part of her community. 10:32

During this period P119 did attempt to take her own life on several occasions. She displayed behaviours that she to my knowledge had never displayed before. She attempted to drown herself in a bath, she put plastic bags over her head to suffocate herself, she even attempted strangulation with anything she could find. 10:32 10:33

Staff must also have been through an awful experience trying to manage P119. I would like to thank them

sincerely for the support they gave P119 during what was an extremely difficult period for them and P119.

P119 had, for her own safety, to be moved to a psychiatric unit at Belfast City Hospital to manage her behaviour and review her medication. We asked why she could not return to MAH for a short period of respite but were advised that it would be too traumatising for her, which I think is an acknowledgment of the impact MAH has had on P119. 10:33

It is my view that BHSCT's failure to implement the external day care placement for my daughter was the most significant reason for what happened to P119 at this time. 10:33

P119 did return to her facility after one week, but still to this day she has not been allocated the external day care placement that was agreed, and still to this day P119 is not the same, and I do not believe she will be until this is resolved. 10:34

The absence of external day care for P119 is despite the requirement of the provisions of her comprehensive needs analysis of 23rd June 2020." 10:34

And the witness provides that at Exhibit 1:

"...and acknowledgment of the care management review of

the 20th January 2021..."

- which is referred to at Exhibit 2:

"...of the importance of a structured day care which is not being provided. 10:34

I regard this as a serious failing in the system of discharging patients from MAH, as even when an appropriate placement is finally found in the community, the supports that are required to enable them to keep them safe and to allow them to live as full and enjoyable a life as possible are very often not there. 10:34

BHSCT is aware of P119's requirements for external day care. They will have known that from when P119 was five years old that she has had access to a day care placement external to where she lived as part of her daily routine. This continued even when she was in MAH, and we were assured that it would be provided as part of the BHSCT's arrangements for her discharge and placement in August 2020, but it is not. 10:35

P119 was 33 years old when she was discharged from MAH and, therefore, external day care had been part of her life for nearly 28 years. It provided P119 with a structure to her day and routine, and I believe that without it P119 would have lost her sense of purpose 10:35

and access to her peer group in the learning disability community. I believe that that loss of this important part of her life led P119 to suicidal thoughts and attempts to take her life, because she was so lonely and saw it as a way of being reunited with her friend who had died. 10:35

I am concerned that the longer P119 is deprived from her external day care the greater the risk that her chances of participating in it fully and enjoying it in the outgoing way that she used to will be compromised. 10:36

I am fearful that P119 may have lost something that has been so important to her and contributed hugely to her well-being and quality of life." 10:36

The witness then goes on to describe some actions that she is proposing to take in respect of that.

I am going to move down to paragraph 70: 10:36

"I believe that the evidence shows that P119's detention at MAH cannot be considered safe. I believe that it took CCTV footage to get P119 out of MAH as opposed to the support of her consultants or those to whom she entrusted her care. I would like an independent expert assessment of P119's diagnosis and medication. 10:36

I believe it is likely to be many years before it is all resolved so that other children and parents do not have similar experiences.

I have found the whole experience very difficult, mentally traumatic, and I believe that I have lost 10 years of being a mother because of the culture that existed in MAH, and P119 has suffered unimaginable levels of abuse and neglect, not simply from the staff on the floor, but from those higher up, who really had a duty of care to protect her. 10:36 10:37

I hope that other children and parents never experience what we have gone through as a family."

10:37

The witness then confirms her wishes around giving evidence and completes the declaration of truth. The statement is signed and dated the 20th of September 2023.

CHAIRPERSON: Yeah. Do you then want to turn to those paragraphs from 36 onwards? 10:37

MS. TANG: Yes. Yes, Chair.

CHAIRPERSON: So at this point the full Restriction Order takes effect, and I am going to ask for the feed to Room B to be cut, please and only those remaining in the room should be CPs or those who have signed a confidentiality agreement. Okay. Thank you. 10:37

RESTRICTED SESSION COMMENCED

THE INQUIRY RESUMED, AS FOLLOWS, AFTER THE RESTRICTED SESSION

CHAIRPERSON: We can now reopen the feed to Room B. We're no longer in restricted session. 11:03

The next statement which is to be read is P123's sister, and I've got a note that we shouldn't start that until 11:30 I think.

INQUIRY SECRETARY: The witness has arrived. 11:03

CHAIRPERSON: Ah, excellent. Fine. Well we better give counsel -- are you dealing with that as well?

MS. TANG: Yes, I am indeed, Chair.

CHAIRPERSON: I think we'll take -- let me just have a look at it, sorry. How long is it? 11:04

MS. TANG: 64 paragraphs long, Chair.

CHAIRPERSON: Yeah, I think we'll give you a break, but just if we can keep it to about 10 minutes and then we'll deal with that.

MS. TANG: Of course. 11:04

CHAIRPERSON: Yep. And then we'll take -- I think we'll have to take an early lunch today because P110's mother I think has to be dealt with at 1:30. All right. Okay. We'll just take 10 minutes now, thank you. 11:04

THE HEARING ADJOURNED FOR A SHORT PERIOD

CHAIRPERSON: Thank you. All right. So I think we're

now moving on to P123's sister?
MS. TANG: That's correct, Chair.
CHAIRPERSON: Who I gather is in the room?
MS. TANG: Yes.
CHAIRPERSON: So, welcome, and thank you for coming along to listen to your statement, which is now going to be read. 11:22
MS. TANG: Thank you, Chair.
CHAIRPERSON: There's no order that needs to be made?
MS. TANG: There are no restrictions, and the witness has indicated that she is content for first names of herself and her family to be used. So I'll be referring to her as Maura. She is the sister of a former patient called Peter, who is sadly now deceased, and there are six exhibits to the statement. The statement is dated, forgive me, it's not noted here. It's dated the 22nd of September 2023, and the page reference is 167. 11:23 11:23
CHAIRPERSON: Okay. Thank you.

11:23

PATIENT 123'S SISTER'S STATEMENT READ

MS. TANG:

"I, Maura, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. 11:23

My connection with MAH is that I am a relative of a patient who was in MAH. The relevant time period I can

speak about is between 1959 and 2008.

I am the sister of Peter, who was a patient at MAH. I attached photographs of Peter at Exhibit 1.

11:24

I am the sister of Peter who was born in 1954 and died in February 2009, at the age of 55 years.

He was admitted to MAH in or about 1959 when he was around 5 years old, and discharged in or around June 2008 when he was 54 years old. 11:24

Peter had 11 siblings. He had five older siblings and four younger. Peter was the middle child. Peter, like the majority of our siblings, was born at home. 11:24

My father, Charles, worked on the docks and our mother, Grace, was a housewife. My family was from Derry, which we all still regard as our home.

11:24

My mother thought something was wrong when Peter was born as he could not suck properly. His eyes were initially pink, and our mother thought that he might be blind, but this was not the case, and they turned a vivid blue. His hair was white, as if he had Albinism, but he did not have that either. 11:25

Peter's medical notes record that there were concerns about his development from when he was about 3 months

old.

My family were told that Peter was deaf and dumb from the behaviours he displayed. We did not need to be told this, although he subsequently learned to say some words. For example, he could say "Mammy" and "Daddy" by the time he was admitted to MAH. 11:25

I can remember Peter being on our mother's knee and then lying down on the floor so that he could hear the vibrations on the floor. Peter would primarily make himself understood using gestures, but was also introduced to Makaton by MAH in or about 1995. 11:25

From reviewing records, it would appear that it was recommended in 1981 for Peter to learn Makaton, and so it is unclear why it took from 1981 until 1995 for this recommendation for Peter to be taught to use Makaton, which would give him an effective means of communicating. 11:25 11:26

I am aware that our family was also informed at some stage that Peter was epileptic. I'm unsure as to when this was. 11:26

Peter also seemed to have a learning disability. I am unaware if this was a formal diagnosis, but I believe that it was from the behaviours that Peter displayed, such as being deaf and dumb.

My parents were in unfamiliar territory, as there was no-one in the family with epilepsy or with a learning disability.

11:26

Much later we learned that Peter had some sort of bowel condition. I do not recall when we learned this.

As a child, Peter would run off and disappear for hours on end. I remember him being very strong and was able 11:26
to push right past me and get out of the house, even though I was four years older than him. He would then be gone. He had no sense of fear. On one occasion he was found sleeping in the back of a post van. On another he was found in the bus depot, and then again 11:26
in the Waterside, which is over the bridge on the other side of the River Foyle in Derry. The police would always bring him back.

As soon as he could, Peter attended a school for 11:27
special needs in the local church, but he got out the first day. They were unable to care for him or cope with him and he never went back.

According to records, Peter was admitted to MAH on 26th 11:27
June 1960 when he was 6 years old. I do not believe the medical notes to be correct. As a family we believe he was admitted at a younger age than this.

I do not recall exactly why he was admitted, as I was only about 8 years old, and my older siblings were still quite young. In those days those sorts of things were not discussed with children.

11:27

Peter's records indicate that the basis of Peter's admission was that he had poor powers of attention, he had a speech defect, cannot dress or wash himself, was unable to test psychometrically, and was considered to have a mental age of around 2 years old. He was 11:28 recorded in 1994 as having an IQ range of between 20 and 49.

Peter would wander away from the home, had no sense of fear and was at times destructive." 11:28

CHAIRPERSON: Just to ask you to pause for one second. You read the date of admission as 26th June. I think it is actually the 28th June.

MS. TANG: My apologies. It is indeed. 11:28

CHAIRPERSON: That's fine.

MS. TANG: Thank you.

CHAIRPERSON: Thank you.

MS. TANG: Right. Picking up at paragraph 13.

CHAIRPERSON: 13. 11:28

MS. TANG: Yes:

"I do not recall any discussion about how long Peter might be in MAH and so far as I could understand he was

to be there indefinitely.

This was reinforced by the fact that there was no reference in Peter's care plan to a community package for discharge until 1995, which was 35 years after he was admitted and when he was about 40 years old. I learned this information from his notes and records. 11:28

My family and I believe that Peter was never detained under the Mental Health NI Order 1986. I note now that Peter's medical notes indicate that the continuing treatment authorization for Peter being placed in MAH under sections 39 and 30 of the Mental Health Act NI 1948, appears to have been periodically extended. 11:29

Peter cried when he was left in MAH, and our father cried too. My father once went to visit Peter and was not able to go back again. My mother said that my father could not accept Peter having to be in MAH and could just not cope with it. 11:29

Our mother had periods when she was unwell and could not visit Peter, but she would write regularly to MAH enquiring about his progress. Indicative is a letter written two years after his admission in 1969 to MAH, which I attach at Exhibit 2. 11:29

I also attach a letter at Exhibit 3, which she wrote in 1967.

Apart from my mother's health, there was the difficulty of making the round trip from Derry to MAH.

Local families in Derry set up a mini-bus to take families to see their loved ones in MAH. My family would go every month to see Peter, with the younger siblings taking it in turns, as there was only so much room on the mini-bus. 11:30

It was a big deal for us going up once a month. We would see him in the sitting room, and then go to the cafe and on walks around the grounds of MAH. My mother was always worried when we were out that Peter would run off in front of a car. My mother would cry every time when leaving MAH. 11:30

My family would always take Peter up sweets and treats when visiting. Peter became less interested in lemonade and sweets after he was introduced to cigarettes in MAH. We were all quite shocked that he could be introduced to smoking at MAH and that he was permitted to become totally addicted to cigarettes. 11:30

Staff in MAH would give him a cigarette but then when he looked for another they would tell him he had to wait. It was a torture to Peter giving him a habit. He would always ask the family to bring him cigarettes. I remember that when we gave him his cigarettes he 11:30

would want to smoke ours too. Peter's notes indicate he smoked approximately one cigarette every hour.

When my siblings and I got older and got our own cars, we were able to see Peter more often. Peter was aware of who we were, even if we came in different cars. We would always get him out walking and sometimes a trip around the airport. 11:31

We did not have serious concerns during Peter's time in MAH, but on one occasion he had a scratch on him, and when I asked what happened I was told a patient did it . I did not query that. I have never seen a body map while he was in MAH, but I never asked. Some staff were very nice and would have talked about Peter. 11:31

As family we were never kept informed about social events or activities. We placed a lot of Trust in MAH and assumed that he was kept busy and having fun. And I now hope that this was actually the case. 11:32

My sister Margaret and I remember that there were locked doors in MAH, and we were not allowed to take Peter out until we were older. I have subsequently seen a letter from MAH dated 22nd June 2007, which I attach at Exhibit 4, in relation to this issue of patients being kept locked up. 11:32

On that basis, Peter was moved from Movilla B to

Conicar Ward. My family is now of the view that Peter became institutionalised in MAH.

I was unaware of Peter being on any medication, although I note from his records that he was on Chlorpromazine. 11:32

Our family had no concerns about Peter's personal hygiene. He always seemed clean, apart from his hair and his ears, which he would not allow anyone to touch and we never discovered why. I would do Peter's hair. 11:32

Peter liked to be smart and liked nice clothes. When MAH tried to put Peter into scruffy clothes he would tear them up and refuse to wear them. 11:33

My family did have some issues with MAH whilst Peter was there, but we never raised them, as we were afraid that Peter may have suffered repercussions if we did.

Whenever we went to see Peter, he would hug and kiss us and point to his bottom. He frequently pointed to his bottom, and we were never able to understand it. I now see in his notes that there were several references to him having rectal bleeding, which is recorded as being self-induced, and developing pruritus ani. I am unclear about what brought that about and it does not appear to have been investigated. 11:33

Peter would also shake his fists at certain workers, and when we asked the staff why he was doing that to them they said, "That's just how he gets on."

With hindsight, my family remains concerned about the possible significance of Peter's behaviour, and we are worried that it might signify that he had been hurt. 11:34

When Peter was in MAH we never really had any concerns as a family, and my mother certainly did not. My mother was old-school and completely trusted doctors and nurses. My mother would talk about staff, and particularly staff who were fond of Peter. 11:34

I note that Peter's medical notes and records refer to him absconding on a number of occasions in 1985. My family was unaware of this, although it was known that as a child he wandered off, and this was one of the reasons given for him being placed in MAH. 11:34

I am unaware of what steps to minimise the risks to Peter being involved in an accident whilst out of MAH, particularly given that he was unaware of danger and was profoundly deaf. 11:34

By January 1994, there was a possible date of April 1994 for Peter's final discharge, and following a review at Moylena on 25th October 1994, he was regarded as an ideal candidate for a community placement. The

social worker was asked to assist with the referral.

Peter's sister, Kathleen, cautioned that Peter dislikes change intensely, and referred to the difficulties caused when he was moved within MAH and suggested a highly supervised unit. 11:35

As part of the overall assessment of Peter for a community placement, a comprehensive nursing assessment was completed on 21st January 1995. I refer to this document at Exhibit 5. There was also a care management report from the social worker dated 15th February 1995, which I refer to at Exhibit 6. 11:35

I believe that all the comments from those who either worked with Peter or knew him best should have been properly factored into any placement, to give it the best chance of success for Peter and avoid a disruptive and damaging failed placement for Peter. 11:35

11:36

In August 1995, his social worker identified two possible new developments of high dependency units in Omagh that might be suitable for Peter, one forecast to open in autumn 1995, and the other in Easter 1996. These did not materialise for Peter. 11:36

The option of a residential home near Derry for people with a learning disability, the Old Mill House, New Building, and catering for eight residents, was

pursued. I am only aware of this information from medical records. My family had been trying to get Peter back to Derry, which was where the family was from.

11:36

On the 2nd June 1997, Peter was discharged from MAH on a trial placement to the Old Mill. I am unsure how this came about. Peter was 42 years old and had been in MAH for well over 30 years. The home had felt it necessary to ensure that Peter was never unsupervised in the grounds and had placed locks on the outside and his room doors. Again, I am only aware of this information from Peter's records.

11:36

I do not know what the process was placing Peter in Old Mill. I do not know how Peter was prepared for a transition from MAH to life in Old Mill, which was essentially supported living, given that he had been living in MAH for almost all his life were all his needs were catered for.

11:37

11:37

There does not seem to have been any proper assessment of appropriateness of placement or that Peter was properly prepared for the change.

11:37

I recall that it quickly became clear that Peter could not settle in the Old Mill. He ripped the curtains down and had his suitcase ready. He was unhappy and wanted to go back to MAH, as that was all he knew.

Peter was readmitted to MAH shortly after he was placed in the Old Mill. Peter's placement had broken down and he obviously needed somewhere he could be appropriately cared for and would be safe. 11:38

My family and I continued to visit Peter regularly when he was readmitted to MAH. Family members would take turns and he would have a visitor one Sunday a month. 11:38

Peter was always very happy to see us. As, family whoever would visit him would take him out for a drive. He was brought shopping, and being a typical man he did not enjoy shopping. He was brought to Nutts Corner Market and he enjoyed fresh air. 11:38

His favourite part of getting out was going in the car, and he was car mad. He would motion with his arms to go faster and laugh. 11:38

Peter would always be watching for us coming and loved to see us. He was very placid and loved his nieces and nephews. Peter was very good natured and had a mischievous personality. Peter was good at swimming and we as family hoped that he was able to use the swimming facility at MAH. 11:38

Peter was in MAH for approximately 12 more years before he was finally discharged and placed in a supported

living facility in Lisburn, as Windermere.

Peter slowed down in later years and was very quiet, but still always very happy to see his family.

11:39

During Peter's time in MAH, he was identified as having a number of medical issues, including recurrent serious ear infections, resulting from a pattern of inserting foreign objects, dermatitis herpetiformis, epilepsy, and chronic renal failure. These required several 11:39 investigative procedures, including to deal with his rectal bleeding, remove objects from his ears, and treatment of severe infections, removal of cataracts from both eyes in 1998 and 2002, as well as a sigmoid colectomy in March 2005 and management of his chronic 11:39 renal failure that had been diagnosed in January 2000.

My family and I were not, however, aware what Peter was hospitalised on several occasions. We were aware on one occasion, but we were not permitted to visit him. 11:39 My family and I are not sure if that is because MAH did not permit it or because my sister, Kathleen, who was Peter's next of kin, did not permit it.

Kathleen does not get on with my siblings and I and, 11:40 therefore, cannot provide answers in relation to this. We did not ask MAH any questions about this at the time.

The most serious of Peter's conditions was his chronic renal failure. There was discussion of a transplant with the Consultant Nephrologist at Antrim Area Hospital in June 2006. My family were informed and we were keen to be involved. Ultimately the Consultant Nephrologist at AAH suggested, in July 2007, that they should defer a transplant to first see how Peter got on with dialysis, with the position being reassessed later. 11:40

Peter's younger brother Jim was a match and had completed and signed the paperwork, but died before Peter could benefit from it. 11:40

My family subsequently found the paperwork and we want to know why the transplant did not go ahead or why Peter was not put back on the transplant list after Jim died? 11:40

Whilst my older sister Kathleen, who was MAH's point of contact, may have been aware of the details of Peter's move to Windermere, myself and Peter's other siblings were not. I am not aware if Kathleen knew or not. 11:41

I am now aware that in or about 2008, there seemed to be a big push in MAH for resettlement, but there was no effort to involve the whole family, even though MAH was aware that Peter's other siblings cared about him and would regularly visit him. 11:41

I would have expected that special care would have been taken with any placement for Peter, given the length of time he had spent in MAH and the spectacular failure of the Old Mill placement. I doubt this was the case. 11:41

I subsequently met a man, H585, and learnt from him that he had been at Peter's funeral, had met Peter in MAH and had worked in Windermere whilst Peter was there. His information has simply added to our concern 11:42 about the appropriateness of the decision to place Peter in Windermere.

I understand that Windermere is a supported living service providing personal care and housing support 11:42 with support workers available 24/7. It was a cluster of houses catering for about 10 residents in total, with each house having about three or four residents, each with a communal living area and kitchen. 11:42

My siblings and I are unaware of how Peter was assessed for discharge, or how his suitability for Windermere was assessed, and I would like the Inquiry to investigate the process that MAH used. 11:42

I have learned from H585, and others, that no real preparation was done with Peter for his move to Windermere.

Our family would like the Inquiry to investigate the process of transition, as we are aware that this is ongoing with the remaining patients in MAH.

We also hold failures in the assessment, preparation and transitioning process as largely responsible for what happened to Peter when he was placed in Windermere. 11:42

I would now consider that at the time of transition Peter was not suitable for any kind of independent living. None of the assessments and papers prepared prior to his trial placement at Old Mill in June 1997, that my family has seen, suggest that he was capable of living in that way. Also, the subsequent failure of the Old Mill placement should have made that clear. 11:43 11:43

MAH would have been aware of Peter's medical condition and his renal failure. He was clearly unwell. He had had major bowel surgery and had been losing weight. I have provided photographs from which Peter's weight loss and frailty is clear, which are attached at Exhibit 1. 11:43

My family now knows that on 26th June 2008, around the time that Peter and the other patients were being transitioned to Windermere, the RQIA had carried out an unannounced care inspection, which recorded that there were no areas requiring improvement. 11:43

My family also now knows that in 2011 and 2012, concerns about the care of residents at Windermere were reported to the Society of Parents and Friends of Muckamore (SPFM). I am particularly concerned to learn 11:44
issues were being raised about levels of staffing, the training and experience of staff for the very vulnerable people with challenging behaviour they would be working with, and the safety of residents, especially concerning the training of staff 11:44
administering medications.

I believe, especially given H585's information, that this is likely to have been the position whilst Peter was there in 2008 to 2009. 11:44

My family has no confidence in the reliability of the RQIA report of 2018, as it has also provided a similar report in 2011, after SPFM brought the concerns to the then Health Minister, Edwin Poots, and yet existing and 11:45
ex-members of staff had felt it necessary to contact SPFM in 2012 to report that nothing had changed. If anything, it was worse.

My siblings and I understand that the RQIA and its 11:45
system of inspections are supposed to give families confidence in the appropriateness of facilities and the safety of their loved ones when there.

We also understand that there are numerous accounts of the RQIA reporting that all is in order, when it clearly was not, and I refer to the abuse of patients in MAH.

11:45

My family would like the Inquiry to investigate the effectiveness of RQIA's inspections, how it was able to miss the failures, and what is required to deliver effective quality control for vulnerable patients, residents and their families? 11:45

I now understand that Windermere was intended to be Peter's home that he would share with others. I believe that careful thought should therefore have been given to the mix of residents, but I now understand 11:45 from H585, and the others, that no real thought was given to that. Rather, those who were in the same ward in MAH were moved together to Windermere.

Because patients are on the same ward in MAH, which is 11:46 not their choice, they should not necessarily be required to live together in what is to be their home. It should not be assumed that they do not care who they end up living with or that their wishes are unimportant. 11:46

My siblings and I are unaware of how Peter was assessed for discharge or how his suitability for Windermere was assessed. We would like the Inquiry to investigate how

decisions on the discharge of patients to a common placement are made by MAH and/or the Health and Social Care Trust.

My family and I found out that Peter had been moved to Windermere by chance. No-one informed us. My sister Margaret had telephoned MAH to let staff know she was coming up to visit Peter and was told "He's been moved. He's in Windermere." As a family we would always have telephoned in advance of a visit. My sister was in shock and had to ask them for directions as Lisburn was unfamiliar to her coming from Derry. 11:46 11:47

We are concerned about having discovered about Peter's move in that way. We do not understand how MAH could have failed to let us know about when he was moving or where he was going. We were not distant family. The staff looking after Peter in MAH knew that a family member visited him once a month. 11:47

After Margaret's telephone call to MAH she found Windermere and went to see Peter. She told me that her immediate view was what it was unsuitable. Peter was very frail, was clearly unable to contribute to looking after himself in any form of independent living, and it was difficult to see how he could be happy living there. 11:47

My family commented that over the time they had visited

Peter at Windermere he got thinner and deteriorated. The last time any of us saw him he could hardly walk. We had to support him getting back into the house, and then he just dropped onto the sofa. Margaret said she had asked the staff whether he was okay and was told that he was just tired.

My family was aware that Peter was in Lagan Valley Hospital and the Royal Victoria Hospital while he was in Windermere. We understand from H585, who worked in Windermere, that Peter was having blood transfusions. However, I think that this actually must have been dialysis Peter was getting, as the process can look the same.

We also now understand that prior to Peter's death the underfloor heating in the house was broken, which meant that it was unbearably hot and would have been constantly about 45 degrees. Apparently to address that, the staff would open all the windows, which is clearly an unacceptable situation.

We have also learned he was unable to properly deal with his personal hygiene and that he would sometimes be found lying on his bed with black stuff coming out of his bowels. We have found that information and image of our brother heartbreaking.

We have since discovered from H585 that a member of

staff had to go for counselling in relation to the conditions Peter was living in.

I have found out that in late 2008, district nursing were expressing the view that Peter required specialist nursing care environment rather than supported living, and that there were concerns in December 2008 reiterating concern about Peter's physical health. I learned this information from Peter's notes. 11:49

My sister Margaret and I went up to see Peter when we found out he had died. All I remember was that Peter was lying on his bed, naked and freezing cold, with a sheet over him. Margaret asked what had happened and was told that he fell when going to the bathroom. We never found out any further information. Our family are unaware of any serious adverse incident reviews concerning Peter's fall on the way to the bathroom and his subsequent death. 11:49

My siblings and I would describe Peter as a beloved brother who loved his family and anything to do with cowboys. We never understood what essential treatment was being provided to Peter that required him to be in MAH for so long. We never questioned his care in MAH as we did not want to upset the apple cart, and would have been afraid that if we said anything negative then Peter would suffer the consequences. 11:50

My siblings and I believe he could have been properly and happily cared for in MAH and he should have been given the chance to experience life out of a psychiatric hospital setting.

11:50

As to the impact on family life of Peter's admission to MAH, his youngest sibling was born after he was admitted to MAH and so he never experienced early family life with him. Also the twins were very young, and Peter would have had little experience of them, and they would all have had little memory of family life with him. 11:50

Furthermore, both of Peter's parents died before he was discharged from MAH. His father in 1972 and his mother in 1975. I believe my mother died of a broken heart at only 56 years old. She said she went into hospital to get her diabetes stabilised, but was worried all the time about not being able to see Peter. She had a heart attack and died. Peter's younger sister and three of his brothers also died while he was still in MAH. 11:50 11:51

Peter died at Windermere on the 1st of February 2009, just eight months after he had been moved there from MAH. This is a major concern to my family. 11:51

In addition to wanting the Inquiry to investigate the possible failures and decision-making which led to

that, we would like the Inquiry to investigate the failures and successes in resettlements from MAH so that it can make recommendations about best practice.

As a family we are aware that the Department of Health has announced that MAH is to be closed in 2024, and there will therefore be a series of placements. My siblings and I also believe that even after that, there will continue to be a need to make appropriate decisions on placements of vulnerable people. 11:51 11:52

All told, Peter was in MAH for 50 years, spending virtually all his childhood and adulthood there, and he was only able to experience life out of there for a brief period, by which time he was ill and frail. We believe Peter could and should have been cared for either in or close to his home city, Derry. His tombstone in Derry reads: "Home at last". 11:52

Finally, my family and I only learned about abuse at MAH after Peter had died. We were shocked and devastated. 11:52

There was no CCTV when Peter was in MAH to disclose how he was treated, and ever since the scandal broke we have worried about whether Peter was abused and that maybe somehow we missed signs. 11:52

We would like the Inquiry to investigate what was

happening on the wards before the CCTV was installed for the good of all those, like Peter, who were there at that time.

My family and I want to give Peter a voice by my participation in the Inquiry, as we feel he was seriously let down by the system, as was the whole family. 11:53

My parents placed him in MAH and would have trusted that that was the right thing to do and that he would be properly and safely looked after. For their sake, and Peter's, I wish to find out if that was the case." 11:53

The witness then goes on to confirm her indications regarding giving evidence, and the statement is signed after a declaration of truth, dated the 22nd of September 2023. 11:53

The witness has provided some photographs of Peter, which are at Exhibit 1, and if we could bring those up, please? She has referred to them in the statement as well. 11:53

CHAIRPERSON: Yes. So it's page 18?

MS. TANG: It is page 167-18. Thank you. 11:54

CHAIRPERSON: I think if we go back to the first one actually. Okay. That's it.

MS. TANG: Thank you, Chair. I wasn't proposing to read through the other exhibits, they have been

mentioned in the statement.

CHAIRPERSON: No, I've looked through those in any event. Thank you very much. And can I just thank all the family who have attended, especially to Maura who has made the statement. There was particular reference 11:54
to resettlement and, as you will know, that is certainly well within our Terms of Reference as something that we will be considering with care and, so I just want to give you the reassurance that you have given Peter a voice and we've listened to that very 11:55
carefully. So, thank you very much indeed.

I think the next witness we can't start until 1:30?

MS. TANG: Yes. That's correct, Chair.

CHAIRPERSON: All right. Can I just say that because 11:55
that witness is going to be Zoomed, this room will be closed between 1:00 and 1:20, there'll be no access to it so that the Inquiry staff can set that up and make sure the Zoom is working. So we'll sit at 1:30. 11:55

I've also got a short announcement to make about the future schedule, but I'll do that at 1:30 as well. Thank you very much.

LUNCHEON ADJOURNMENT 11:55

THE INQUIRY RESUMED, AS FOLLOWS, AFTER THE LUNCHEON ADJOURNMENT

MS. TANG: Good afternoon, Chair and Panel. This afternoon you'll be hearing the evidence of P110's mum. She is appearing this afternoon via Zoom and a member of the Inquiry's admin staff are with her. 13:34

CHAIRPERSON: Sit down. It's easier if you sit down.

MS. TANG: Thank you, Chair. Thank you, Chair. Yes, I'll begin again. 13:34

We'll be hearing from P110's mother this afternoon. She is appearing via Zoom, and members of the Inquiry team are with her, and her own legal representatives, to assist from her home. 13:34

CHAIRPERSON: And who else is in the room with her?

MS. TANG: We have two members of the Inquiry team and her solicitors from Phoenix Law are in attendance with her. And her uncle.

CHAIRPERSON: Right. 13:35

MS. TANG: Is in the room with her as well, as a supporter.

CHAIRPERSON: Okay. That's great.

WITNESS: Sorry, excuse me. My son [redacted] is here as well. 13:35

MS. TANG: Your son is with you?

CHAIRPERSON: All right. That's fine. All right. And how does the witness wish to be referred to?

MS. TANG: The witness will be referred to as P110's

mother.
CHAIRPERSON: All right. Okay.
MS. TANG: For the purposes of this.
CHAIRPERSON: All right. Welcome. Can you see and hear me if I speak? No. Right, you can now. 13:35
WITNESS: Yes, I can. Thank you.
CHAIRPERSON: All right. Welcome to the Inquiry. We spoke a little bit earlier. I'm going to hand you over to Ms. Tang, who is going to read your statement over to you. All right? 13:35
WITNESS: Thank you. Thank you very much.
CHAIRPERSON: Thank you very much.
MS. TANG: Thank you, Chair.
CHAIRPERSON: I gather there's an application also for a Restriction Order in relation to part of it, is that 13:35
right?
MS. TANG: Yes. There is indeed, Chair. There'll be an application for a Restriction Order for elements of P110's mother's evidence. I will make the application and I would ask that the application itself be made 13:35
subject to restrictions.
CHAIRPERSON: Right. I'm going to cut through this because the witness is on-line and it may be confusing to the witness, but I understand that the application is in relation to paragraphs 25 onwards. 13:36
MS. TANG: Yes. Correct.
CHAIRPERSON: It is for reasons that we know well.
MS. TANG: Yes.
CHAIRPERSON: If necessary, if anybody wants to hear a

full application, a full application can be made, but I'm going to make now a temporary Restriction Order in relation to all of that material and, indeed, any oral evidence, if there is any.

MS. TANG: Yes. 13:36

CHAIRPERSON: And then we will draw up the formality of the Restriction Order later.

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

CHAIRPERSON: All right. But in the meantime we're not under a Restriction Order for the first 24 paragraphs. 13:36

MS. TANG: Yes. That's correct.

CHAIRPERSON: Excellent.

MS. TANG: Thank you. Good afternoon, P110's --

INQUIRY SECRETARY: Sorry, Chair. We need to do the oath first. 13:37

MS. TANG: Oh!

CHAIRPERSON: Yes, we do.

MS. TANG: My apologies.

INQUIRY SECRETARY: So, they have it there.

CHAIRPERSON: All right. 13:37

MS. TANG: Okay. Yes, we just need to do the oath at this moment in time, P110's mother, and the Inquiry member of staff, Stephen, I believe, is going to do that for you now.

13:37

<u>P110'S MOTHER, HAVING BEEN SWORN, WAS EXAMINED BY MS. TANG AS FOLLOWS:</u>

MS. TANG: Can you hear me okay, P110's mother?

A. Yes, I can indeed. Thank you.

1 Q. Thank you. As you know, my name is Shirley. I'm one of the barristers on the Inquiry team, and I am going to be reading your statement this afternoon, and at the end of that, if you wish to add anything or to say anything, then you're free to do so. 13:37

So if I can ask you to listen to what I read in just now and then I'll come back to you.

13:38

The statement is dated the 5th of September 2023, and there are five exhibits to the statement?

CHAIRPERSON: Hold on a second. Oh, I see. All right. As long as the witness is still there. I can't see her but we'll carry on. 13:38

MS. TANG: The internal page reference for the statement is 144.

CHAIRPERSON: I'm sorry actually, I'm going to stop this for a moment. If this statement is being read, everybody can read it, they have their own copies. I think it is much more important that we see the witness than we see the exhibit on screen. So, apologies, I should have made that clear earlier, but I want to see the witness. Right. Back again. Okay. Thank you. Sorry. 13:38

MS. TANG: Yes. Thank you, Chair. I'll just begin reading.

The statement is dated the 5th September 2023.

"I, P110's mother, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry.

My connection with MAH is that my son, P110, was a patient at MAH. 13:39

The relevant time period that I can speak about is between 2013 and 2019.

13:39

I am the mother of P110, who was born in 1987 and is currently 35 years old. P110 has an older sister aged 38 years old. P110's father has not been involved in his life since our divorce, when he was about 8 or 9 years old. P110 has an exceptionally close 13:39 relationship with his maternal grandparents who visit him every day.

P110 suffers from congenital heart disease and neurodermatitis. He is diagnosed as having marked 13:39 developmental delay coupled with a consequent impairment of intelligence, which is believed to be as a result from a loss of oxygen associated with his heart condition.

13:40

Whilst P110 is fiercely independent, P110 requires assistance with his personal hygiene and dressing himself.

P110 requires the constant support of oxygen and a condenser, which equates to 10 cylinders per week.

Both my pregnancy and birth were normal, however shortly after P110 was born I felt that he was struggling to breathe. I reported this to the doctor at the Ards Community Hospital in Newtownards who thought that P110 had a heart murmur. 13:40

P110 was transferred to the Ulster Hospital, investigations were conducted and P110 was diagnosed with a suspected hole in the heart. 13:40

P110's heart kept stopping and he had to be resuscitated. 13:40

P110 was sent to the Royal Belfast Hospital for Sick Children when he was only a few days old. He was examined by a paediatric cardiologist and a paediatric cardiothoracic surgeon. The hospital concluded that P110 had a rare congenital heart abnormality in that the left side of his heart was the wrong way around and underdeveloped. I could not understand how P110 was still alive, given the malformation of his heart. 13:41

P110's father and I were told that his only chance of survival was surgery, but that carried high risks. We were given the option of switching off the machine that was providing P110 with oxygen. 13:41

The surgery took around 11 hours, and P110 was placed in the Neonatal Intensive Care Unit. We were told that he was the first baby born in Northern Ireland with that condition to have survived.

I visited every day staying for hours with P110.

There were a series of problems. P110 deteriorated and he was at risk of choking. He required a tracheostomy and to be PEG fed. I was effectively living at the hospital until P110's cardiologist suggested that I stay in hospital accommodation to make things easier for me than travelling every day from my home town.

I practically lived at the hospital for four years whilst P110 underwent a series of procedures and awaited a further major operation, a Fontan procedure, which was performed in 1995 when he was about 7 years old.

When P110 was finally discharged home he continued to experience difficulties. He was unable to maintain his breathing and he invariably ended back up in hospital, such as in 2003 when he had a pacemaker system fitted.

Any surgery for P110 was always lengthy, complex, and pioneering. I would essentially live at the hospital while P110 continued to receive treatment.

P110 did not attend school at all before the age of 14, given his medical history. The loss of oxygen P110 suffered due to heart condition caused him difficulties developmentally. 13:43

I had taught P110 life skills at home, such as how to use a knife and fork, but I wanted P110 to receive an education.

13:43

P110 attended a school when he was about 14 years old and stayed for around two years until he was 16 years old.

P110 spent a period of his adolescence between 14 and 18 years in a care home to provide me with respite. Thereafter, he attended a facility which provides services for adults with learning disabilities. 13:43

We were given a poor long-term prognosis for P110, who was also aware of his uncertain future. 13:43

P110 received respite care at a children's hospice until he was 19 years old.

13:43

P110 was afraid that he would be sent to MAH. I did not know about MAH personally at this time, but there was chat amongst the mental health and learning disability community about MAH, which had a terrible

reputation as being the place where you did not want to be sent.

P110 said that MAH was used as a threat, and if P110 did not stop asking when I was coming to see him he would be sent to MAH. 13:44

A carer told me that one of the night carers said "Your mummy is not coming to see you", to P110. I do not know why he was being taunted in this way. That facility were having difficulty managing P110's behavioural problems, including punching the wall and making a hole in the plasterboard, damaging furniture, and being verbally and physically aggressive. 13:44

I believe that there was a multidisciplinary meeting between the facility and the Board and it was decided that P110 would have to be transferred to MAH. I was not involved in this meeting or discussion surrounding P110 being admitted to MAH, rather I was informed as an afterthought that P110 would have to be transferred to MAH. 13:45

The police were called and P110 was taken away in handcuffs to MAH on or about the 9th of August 2013. I believe P110 was detained under mental health legislation. 13:45

This was P110's first admission to MAH, and he was

placed in Cranfield 1.

P110 was crying when he was admitted to MAH. He thought it was a prison.

13:45

Initially P110 was to be detained until the 22nd of August 2013. However, the period of assessment was extended until the 27th of August 2013 when P110 was discharged to a care home.

13:45

P110 was readmitted to Cranfield 1 in MAH on 5th September 2014, initially on a voluntary basis. However, he was then detained under the mental health legislation on the 9th of September 2014, based on challenging hostile behaviour towards staff and patients.

13:46

The medical report claimed that P110 required a high level of supervision and treatment to reduce those risks and that there is no suitable community facility which could meet his current treatment needs.

13:46

P110 was discharged back to the care home on 29th October 2014.

13:46

I disagree that P110 would ever display this behaviour.

The staff at the care home reported challenging behaviour within a week of discharge in October 2014.

Example, for damaging property and hitting another resident.

P110 was taken by police to A&E Ulster Hospital as a place of safety on the 11th November 2014. He was found he did not meet the grounds for compulsory admission, but it was agreed that voluntary admission was necessary at this time due to his presentation. 13:46

P110 was taken by ambulance to MAH on 27th November 2014 and was admitted for assessment based on his aggressive behaviour, damaging property, as well as causing staff and other residents to be fearful of their safety. The initial period of assessment was extended following a series of reports. 13:47 13:47

The common basis for P110's detention was P110's aggression and the inability to be risk managed within the community. I was never informed on what treatment P110 was receiving whilst in MAH, and felt he was being placed in MAH as opposed to receiving any meaningful treatment. 13:47

A medical report in 2018 refers to P110 remaining in his bedroom, refusing to get up or washed, and that he needed encouragement to eat and drink. 13:47

I was not given any proper information surrounding the reasons why P110 was being admitted to MAH, what

treatments or assessments he required, or how long he might have to stay there, or what would determine his discharge.

I have seen the records upon which P110's detention was based and do not consider these to be serious enough to warrant an admission to a psychiatric hospital. 13:48

P110 was readmitted to MAH from 2014 to 2019. I was told that I would not be able to see P110 for an initial period. I believe a period of eight weeks was required to allow P110 to settle in. 13:48

I had no communication were MAH during this period on how P110 was getting on. I was not allowed to phone or to visit. This was horrific for me. P110 is my whole life. Not being able to speak to him was mental torture for us both. 13:48

After the eight week period had passed, I telephoned MAH to see how P110 was, and was invited to a meeting at MAH. SW2, P110's social worker, and a psychologist were present at the meeting, along with another lady who was taking minutes. During the meeting I was told that P110 was pleasant and that if I wanted to see him we would have to talk about it. 13:48 13:49

I told them that of course I wanted to see P110, and the response was "That is not how it works here", that

they would have to ask P110 if he wanted me to visit.

The next week I received a telephone call in which I was told what I could see P110 for an hour from 10.00am to 11:00am on the Thursday morning, with a nurse in attendance and another nurse outside of the door. They said that this was for my own safety. 13:49

The nurse who remained outside of the visiting room had a microphone to tape us. I was told there was also a camera and it would be used to monitor the visit. This happened at every weekly visit for two months. I was told that they wanted to hear what P110 was saying to me. 13:49

Throughout these visits, P110 cried all the time and held my hand so tight it used to turn purple. 13:50

I have never seen the footage that was recorded. I raised concerns over this but nothing was ever done about it. 13:50

I travelled to see P110 once per week. On the first visit I saw P110 in the visitor's lounge of Cranfield 1 for one hour. I was told that I could not see him for any longer than one hour per week, and this was deeply distressing for me. 13:50

P110 seemed withdrawn and frail but was always happy to

see me. He held my hand and would ask me when he could come home. He told me he was frightened. I would tell him "soon" as I wanted to reassure him without giving a date that I could not guarantee. I asked many times when he would be discharged and recall on one occasion H50 said "how long is a piece of string?" 13:51

I was not permitted to take P110 out for the first year that he was in MAH. During that year I only saw P110 in the visitor's lounge of Cranfield 1. 13:51

P110 was nervous when I was leaving, holding my hand very tightly. I brought him treats and he would ask me about his grandparents. P110 never got the treats I brought, as the nurses would give them to others instead. P110 would hug me and then the nurse would say,"Time to let mummy go." He would be abused for it. P110 told me this. 13:51

Over time P110 became cautious about what he would say to me and did not take his treats. He seemed unhappy and withdrawn. I felt that it might be that it was an unhealthy environment for him and too long between visits. 13:51

I would take him to Cosy Corner once that was permitted, but a nurse would have to come with us. I would always ask for privacy for visits and never got it. The staff would always be with us. 13:52

I noticed P110's fingernails had not been trimmed but that he had bitten them. I noticed marks on his hands. I was aware of P110's skin condition, but sometimes the marks on his hands appeared different. When I asked P110 about this, he said that he could not remember."

Chair, at this point...

CHAIRPERSON: Yeah. So the Restriction Order now comes into effect. Could I ask for the feed to Room B to be cut, please. 13:52

THE INQUIRY COMMENCED A RESTRICTED SESSION

THE INQUIRY RESUMED AFTER THE RESTRICTED SESSION

CHAIRPERSON: Okay. Right. Now we were going to have another statement read this afternoon, that of P116's mother. She was originally going to give evidence, and then her statement was going to be read, but I gather that she is unwell, and I also have had representations made to me that she is very keen to be able to say something at least to the Panel. 14:23

As everybody will understand, our schedule for the last week is extremely, extremely tight, but it is through no fault of her's that this witness was unable to be here today. And, so, I have acceded to that application, and we will find a slot to schedule her in the last week of the patient experience. Although, as I say, I think they will be long days - I better warn everybody, I think those are going to be long days for all of us. 14:24

Can I then say a few words, please, about the remaining evidence relating to the patient experience in the next phase of this Inquiry? 14:25

As you will be aware -- and I am sorry, we are no longer obviously restricted and the feed should be - let me just stop for a second. I think it is important that this is publicly relayed, so we'll wait. I don't need to repeat that part. Okay. 14:25

Okay. Let me just start the comments that I wanted to make about the future schedule again.

As you'll be aware, the "Patients and Relatives Experience" evidence is now coming to an end. The final patient experience evidence will be heard in the week commencing the 9th of October, with this phase of the Inquiry closing on Thursday, 12th October. 14:27

With a very few exceptions we have now received all of the final signed statements from the AFM and SPFM witnesses, and the Inquiry has now heard a substantial body of evidence of that nature, and the Panel wants to say that it is very grateful to all of the many witnesses who have provided statements, and to those who have given evidence of course. 14:27

The Inquiry's Terms of Reference are limited by date and are restricted to the period between December 1999 and June of 2021. The Terms of Reference also allow the Inquiry: 14:27

"...to receive and take account of evidence outside of that period where such evidence will assist the Inquiry in examining, understanding and reporting on matters within these Terms of Reference." 14:28

Having reviewed all signed statements which have not

yet been heard, there are a number of witnesses whose statements fall outside the Terms of Reference, and whose evidence is so far outside the relevant dates that it would not be appropriate for those witnesses to be called, nor for their statements to be read in full. However, I am very conscious that all of those witnesses have an account to give and a story to be heard. 14:28

Part of the role of a Public Inquiry is to ensure that those who are affected by the issues have the opportunity of conveying their experience to the Inquiry where it's appropriate to do so and when that can properly be accommodated. 14:28

So what I propose is that we devote a day for counsel to deal, by way of a summary presentation, with all of those accounts which fall outside the Terms of Reference but which nevertheless ought to be heard. 14:29

Before those accounts are given by way of summary, it is important that each maker of a statement which falls into this category understands that their statement will be read in full by the Panel, and they will form part of the historic record about which the Panel needs to be aware. 14:29

That session, when those statements will be summarised, will be on the last day of the Patient Experience

evidence, which is Thursday, 12th October.

We have written to all of those who have given statements which fall into that category and explained our approach, and we've also written to the solicitors of those who are legally represented, and they've all been notified that that evidence will be dealt with on the 12th. They are welcome to attend here at the Inquiry centre or, alternatively, they can be provided with Zoom links so that they can watch and listen to the summary presentation. 14:30 14:30

I also want to set out where we are with the schedule as we move forward.

14:30

The late receipt of the patient experience statements has inevitably resulted in delay to the next phase of the Inquiry, which relates to the staff experience at the hospital, and although the processes to take statements from staff have been designed and are ready to be put into operation, the process itself has only just been able to start in earnest this week. 14:30

Now, as Chair, I have to ensure fairness to all, and the machinery of a Public Inquiry is complex. Where there is a slowing down in one part of it, that may have a consequent effect on the rest of the process, and that is what has now happened. 14:31

Although we did intend to start hearing from members of staff in the week of the 16th of October this year, that is unfortunately no longer realistic. In reality, we will not be able to start the staff evidence until the 6th November. Now, that means that the Inquiry will not be sitting to hear evidence between the 12th October and the 3rd November, and we will publish the schedule of sitting in due course.

14:31

So our next date of sitting is going to be the 9th October, and because these is such full days I'm afraid we're going to start at 9:30 and we will go through the day until we finish all of that evidence, as we will for the rest of the evidence to be heard.

14:31

14:32

In the meantime, can I thank you very much all for your attendance, and we'll see you back here at 9:30, 9th October. Thank you very much.

THE INQUIRY ADJOURNED UNTIL MONDAY, 9TH OCTOBER 2023 AT 09:30 A.M.

14:32