MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 11TH OCTOBER 2023 - DAY 66

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

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WITNESS PAGE

THE INQUIRY RESUMED ON WEDNESDAY, 11TH OCTOBER 2023 AS FOLLOWS:

IN OPEN SESSION

09:00

CHAIRPERSON: Good morning, Ms. Tang.

MS. TANG: Good morning Chair. Good morning Panel. This morning the Inquiry is going to first hear the statement of P121'S sister being read into evidence. And I should say, Chair, that an application for a 09:00
Restriction Order over the entirety of P121's sister's statement is to be made.

CHAIRPERSON: I'll make a temporary Restriction Order to govern the application.

MS. TANG: Thank you, Chair. 09:00
Can I ask at this stage do we need to have the feed cut.

CHAIRPERSON: That happens nowadays automatically, as soon as I say those words, yes.

09:01

RESTRICTED SESSION:

THE HEARING RESUMED AS FOLLOWS:

IN OPEN SESSION 09:48

MR. DORAN: Morning, Chair.

CHAIRPERSON: Mr. Doran. I gather there is an application for a Restriction Order?

MR. DORAN: Yes indeed, Chair, and I would ask for the application itself to be restricted in the usual way.

RESTRICTED SESSION

OPEN SESSION:

P96'S FATHER, SWORN, EXAMINED BY MR. DORAN AS FOLLOWS:

CHAIRPERSON: Good morning and welcome to the Inquiry. 10:07
You and I have met on a number of occasions.

A. Yes.

CHAIRPERSON: But welcome finally to the witness chair. Can I just say, please, for those members of the public who may be watching from Room B, I have made a 10:07
Restriction Order in relation to quite large parts of the evidence, but it will be clear when that comes into play because we will go into closed session. But I have also made Restriction Order in the sense that there must be no publication of the names P96's Father 10:08
and P96. So there must be no wider publication of those two names, even though the witness and counsel are likely to use them. Okay, Mr. Doran.

MR. DORAN: Chair, I should say that P96's Mother, [name], is also in attendance. I think I had indicated 10:08
earlier that she would be sitting with the witness but in fact she is sitting in the public area.

CHAIRPERSON: Welcome to you as well. Okay.

1 Q. MR. DORAN: P96's Father, thank you for attending to

give evidence today. As you know, I am Sean Doran, counsel to the Inquiry. We met briefly this morning to discuss the procedures and we've also met on a number of occasions before.

A. That's right.

2 Q. We are going to be talking about your son, P96, and specifically about the time that he spent as a patient at Muckamore. I think it's correct to say, isn't it, that your son was a patient at Muckamore from May 2017 to February 2020? 10:09

A. That's right.

3 Q. And you made a recent statement to the Inquiry solicitors?

A. That's right.

4 Q. And I think the statement is dated the 21st of September 2023, isn't that right? 10:09

A. That's correct, yes.

5 Q. And do you have a copy of it with you?

A. Yes, it should be here, yep.

6 Q. Now, as you know, P96's Father, the procedure is basically that I will read the statement and then ask you some questions and the Panel may well have some questions to ask you also. Before we do that I will explain a couple of things that we have already discussed. The first thing is that we are going to deal with your evidence in two parts, as you know, the first part in open and the second in a restricted session. You will see that your statement is marked with the restricted areas so I hopefully will not be 10:09 10:09

touching on those at all in the open session, but we can talk about all of those matters when we get into the restricted session. Another thing that you will see throughout the statement is that when members of staff are mentioned for the most part they are referred to by cipher number and I am not going to be referring to them by name as we go through the evidence and I am going to ask you also to use the ciphers. You have the list of ciphers in front of you? 10:10

A. Yes. 10:10

7 Q. I think. Don't worry if you slip, most people do, we have a mechanism for stopping the recording so don't worry about that at all. So, I am going to read the statement now and we had a discussion also about me possibly summarising some of the earlier sections and I understand that you're happy enough for me to do that? 10:11

CHAIRPERSON: P96's Father, just so you know the Panel have read the whole statement.

A. Thank you.

8 Q. MR. DORAN: Indeed in addition to that, there are quite a few exhibits and detailed exhibits that you have provided. I won't be going through all of those in detail but you can rest assured again that the Panel will read them in full. So I turn then to your statement dated 21st of September 2023. 10:11

"I P96's Father [name] Make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry."

CHAIRPERSON: Sorry, you have just used the surname and we are in open session so I thought the surname was not going to be used, we are simply referring to P96's Father and P96. 10:12

MR. DORAN: Yes, Chair, that's correct. There is a reporting restriction over names in any case.

CHAIRPERSON: Well we should not, I think we should not be using the surname so if we just stick to P96's Father and that should not be reported. 10:12

MR. DORAN: I think, Chair, that's the only reference to the surname in the statement.

CHAIRPERSON: Okay.

MR. DORAN: "I, P96's Father, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. When exhibiting any documents I will number each document so my first document will be Exhibit 1. 10:12

my connection with MAH is that I am a relative of a patient who was at MAH. The relevant time period that I can speak about is between May 2017 and February 2020. I am the father of P96 who was a patient in MAH from May 2017 until in and around the end of February 2020. My wife and I have four children, P96, and his three brothers. I attach photographs of P96 at Exhibit 1. 10:12 10:13

P96 suffers from several difficulties. He has been

diagnosed with autism, a severe learning disability, ADHD, epilepsy, hypertrophic cardiomyopathy and sensory issues. P96 is non-verbal and requires 24 hour care and assistance with feeding, toileting, medicine, dressing, bathing and all personal care." 10:13

And then in paragraphs 5 to 13, P96's Father, you helpfully set out details about P96's development as a child. You also talk about the different schools and facilities that P96 attended when he was younger. I am not going to read those paragraphs in full but I just want to refer to a couple of points that you make that I will return to later. In paragraph 7 you say: 10:14

"The difficulties for P96 arose at least in part due to a lack of adult provision in the community. There seemed to be far less facilities for adults such as P96 than for children with a marked reduction in provision when he turned 19 years old." 10:14

Then at paragraph 9 you make the point that: 10:14

"Aside from his attendance at various facilities P96 had no real experience of being away from the family home for any sustained period until he went into MAH in 2017 when he was 21 years old." 10:14

In the statement you describe P96's behaviour as becoming more difficult when he was around the age of

19 and then in paragraph 13 itself you give the Panel details of an incident that occurred in the family home that led to P96 being admitted to Muckamore some time thereafter. Now I resume then at paragraph 14.

"Due to this incident and on the same day, social workers and doctors attended the family home. The social worker, H580 was very aggressive. They advised that P96 should be detained under the Mental Health Order." 10:15

A. Sorry, can I interrupt there?

9 Q. You can indeed?

A. That was meant to be taken out of the statement because the social worker wasn't aggressive. We came to rely very heavily on that social worker. 10:15

10 Q. I am very content to have a correction made to the statement, maybe what we can do is deal with issues like that at the end, P96's Father, if that's okay.

A. No problem.

11 Q. But I'll take a note of that for now. 10:16

"They advised that P96 should be detained under the Mental Health Order. We were really concerned about this as we knew P96 would struggle to deal with it and so we did not agree to section P96 at that time. The 10:16 social worker, H580, returned on or about the 15th May 2017 to advise that detaining P96 was something they were going to pursue with or without family approval. She explained to us that if we did not agree then they

would have P96 sectioned which would have to involve the police removing him to MAH. This was not properly explained and my wife and I did not really understand the full position that Social Services were seeking to detain P96 and its implications. We were told that Social Services would succeed in sectioning him even if we contested it and then P96 would be taken by the police to any available mental health unit which could be Londonderry, Armagh or MAH. 10:16

During a meeting at the Edgcumbe Centre we reluctantly agreed to P96 being voluntarily admitted to MAH to avoid any involvement with the police as we felt it would be even more distressing for P96, albeit we do not feel this was truly voluntary as we were given no real choice. 10:17

It was our understanding that the purpose of admitting P96 to MAH was for him to be assessed and treated. H580 indicated that the process would take between four to six weeks. She showed us pictures of MAH and described it as being like a holiday village. She said that MAH had been subject to so many investigations it was a very safe place to go. She also said there were cameras everywhere and that it was the most highly staffed and highly trained unit, it was the jewel in the crown. 10:17

When P96 was admitted he went to Cranfield PICU at MAH.

We did have some concerns about the admission process even though we had agreed to it at the time.
On the day P96 had originally been due to be admitted, H580 came to our family home and advised that P96 had been assessed as dangerous but that they had no place ready for him at MAH. She told us we would have to wait for a few more days. The doctor in attendance asked me what my plan was to manage risks posed by P96. This did not inspire me with much confidence as I thought had he was something they should have provided guidance and assistance to us about, the plan should have come from them. 10:18 10:18

P96's medication was increased to help manage the risks of P96 having an outburst. When MAH did have a place for P96 a few days later we said we would take P96 up to MAH in the car, which we did, and walked P96 into MAH without any issue. I was not provided with any meaningful information about the facilities or what we could expect. 10:18 10:18

It became clear that P96 would be staying longer than the four to six weeks we had been told. At a best interests meeting in MAH on the 13th June 2017 we were advised by Dr. H30, consultant psychiatrist at MAH, that P96 would benefit from a shorter, rather than longer admission and that they would plan for discharge later in the summer. I refer to minutes of this meeting at Exhibit 2. 10:19

P96 did not leave MAH until February 2020. We visited P96 in MAH around three times per week. We would have been allowed to take him for a walk around the grounds or to the Cosy Corner cafeteria. We were not provided with nor did we have sight of any care plan for P96 or any risk assessment but we assume that he must have had one. We did not know how to ask for these because we simply did not know that these should have existed. 10:19

I would get calls from staff at MAH regarding P96's medication. Staff did manage to get P96 off sleeping medication whilst he was in MAH and managed to control his ADHD." 10:19

At that point I am going to pause and move on to paragraph 39 which reads: 10:20

"The latest update is in a letter dated the 18th of January 2023 from Bernie Owens, Deputy Chief Executive of the BHSCT and Sarah Templar, Service Manager, Public Inquiry and Trust Liaison, MAH Inquiry which I attach at Exhibit 9. It concedes and apologises for errors and matters inappropriately handled in relation to my concerns and complaints. 10:20

The Department of Health two years after the CCTV abuse scandal broke were still resisting calls for a public inquiry as can be seen in an article in the Irish News

dated 19th May 2019 which I attach at Exhibit 10."

And at the close then of paragraph 40 I am going to move on to resume at the beginning of paragraph 55 where you say: 10:21

"I have concerns over the way that P96 was moved with little or no notice out of PICU where he was well settled to Cranfield 2. PICU was a locked highly controlled six bed ward with specialist staff whilst 10:21
Cranfield 2 was a large open ward. This move resulted from the decision to close PICU at short notice on 21st December 2018 which believe was caused by a staffing crisis.

10:21

I was telephoned by H50 who informed me that P96 would be moved from PICU to Cranfield 2 in an hour's time. This was the first that I knew about this plan, there was no social story to prepare P96 for the sudden change to his routine and environment. I sought the 10:21
details and a copy of the required risk assessment in an e-mail on the 27th December 2018 which I followed up on the 11th January 2019. I did not receive a response until the 14th January 2019, but that did not provide a copy of the risk assessments referred to. Rather, I 10:22
was informed an external evaluation was being carried out by the Health and Safety Executive. It was only in a letter dated the 3rd of November 2020 that the BHSCT finally conceded a risk assessment in relation to

absconding had not been completed ahead of P96's move from PICU to Cranfield 2 on 21st December 2018 and was not in fact completed until the 21st January 2019, well after my complaints. I refer to these letters at Exhibit 13. 10:22

It was well known that P96 would seek to escape at every opportunity. Furthermore, I understand that it would have been a statutory obligation to carry out such a risk assessment. On 22nd December 2018, after I had been told that P96 would be moved to an open ward, we went up to visit him. As we were driving into MAH we saw P96 walking about the car park in his dressing gown with no trousers, shoes, or socks on, in my view P96 had clearly escaped. A Staff Nurse brought out a blanket and a wheelchair to assist with moving P96 inside. The deputy charge nurse told me that she had been demented as P96 had spent the morning escaping. 10:22 10:23

I telephoned the ward that night and was told that P96 had spent the afternoon escaping and it was worse than the morning. I requested the CCTV footage of 22nd December 2018 as I wanted to know how many times P96 attempted to abscond and how many times he got out. I also wanted to know details of whether P96 was supervised during these escapes and whether he was appropriately dressed at these times. I also wanted to know how quickly the staff reacted or became aware that P96 was missing. This took a long time to get and 10:23 10:23

eventually on the 8th August 2019 I was shown the CCTV footage of only the morning, despite having requested to see all day. This showed 11 or 12 attempts by P96 to abscond, more than I had previously been told about. When I asked to view the afternoon footage I was told that they had only prepared the morning footage and they would have to pixelate the afternoon footage if I wanted to see it. I asked for that to happen. Subsequently I was told that the afternoon footage had been deleted. Then I was told on the 17th January 2020 that the morning footage had also been deleted. I sought disciplinary action against the people who deleted the footage but I was told that for GDPR reasons the person or the rank of the person who deleted the footage could not be disclosed. 10:24 10:24 10:24

I have subsequently learned through considering P96's PARIS records that the frequency of absconding supercedes what I was ever advised of when P96 was in MAH. Having considered these records I find it outstanding that the decision was subsequently taken to move P96 to a less secure ward. I believe the notes and records in relation to P96's absconding supervision would be of particular interest to the Inquiry. 10:25 10:25

P96's records from MAH indicate that P96 had form for escaping but we were never told that. So far as I was aware P96's escapes were not treated as SAIs, was confirmed to me by Kathy Jack.

BHSCT correspondence dated 3rd November 2020, and which I attach at Exhibit 14, refers to internal requests of August 2019 and November 2019 for the afternoon footage of the 22nd December 2018, but by the time it was processed and advice sought from radio contact and estates services it was no longer available as the CCTV system had reached capacity, however I do not believe this to be accurate. The letter includes a section from BHSCT's incident reporting system for the 22nd December 2018 which describes three incidents of absconding. Given my experience with MAH and BHSCT I have no confidence in the accuracy of this record. I believe that they say there were only three incidents because they do not count it as an incident unless a patient gets out of the car park.

10:25
10:26
10:26

The same letter from BHSCT also deals with my query as to whether minutes of my meeting with H77 and H155, Adult Safeguarding Officer, on 25th August 2017, were on PARIS. BHSCT confirmed that these minutes were not on PARIS but stated that these minutes had been provided to me earlier by H287. I was surprised that such important information was not included on PARIS.

10:26
10:27

Throughout I have had considerable difficulty in obtaining any information from BHSCT on what happened to P96 and why. Also, when I was given information it was often shown to be wrong and I consider it was

intended to mislead to protect the wrongdoers. I was never shown any MAH brochure, pamphlet or leaflet dealing with the issues that were of concern to me in relation to P96 such as his admission, patient and family rights, medication, relocation within MAH or resettlement from MAH."

And moving on to paragraph 68.

"In April 2018 BHSCT arranged for my wife and I to attend a meeting on the 15th May 2018 with the SAI review Panel. BHSCT's letter of the 30th April 2018 in this regard is attached at Exhibit 16. It is my experience in relation to the handling of my complaint that is included in the review commission by the DoH, Health and Social Care Board, HSCB and Public Health Agency PHA, the complaint referenced above has still not been resolved.

I resorted to making freedom of information and data access requests as BHSCT were not adhering to the law and policy requirements in this regard. They misdirected matters and did not adhere to time limits. I also lodged complaints with the Information Commissioners Office, ICO, over BHSCT's failure to provide information. I requested an investigation to try and obtain information on P96's treatment on 9th August 2018 and 4th September 2018."

And you give the case reference number.

"I was initially dealing with Jim Dunne in the ICO. Jim Dunne confirmed to me that he believed that there had been numerous breaches. I have a letter from ICO dated 26th February 2019 which accepts my complaint. Subsequently there was a change in the investigating officer as Jim Dunne had moved on and a senior officer took over. This senior officer found only a single breach regarding the time scales to comply and even asked me if I wished them to be sanctioned. I confirmed that I did and I understand that this was detailed on the ICO website. 10:28 10:29

I also contacted the Human Rights Commission on 15th October 2018 for assistance. Their view seemed to be that there was a police investigation, and they would maintain oversight. I considered this an inadequate response to what was shaping up to be the worst failure of adult safeguarding in UK history and I am deeply disappointed by the lack of action. 10:29 10:29

I raised further concerns with RQIA on or about the 10th January 2019 regarding P96's care in MAH. I received a response from RQIA on the 3rd May 2019 which advised that they had completed two unannounced inspections at MAH in February 2019 and April 2019 and would continue to monitor the quality of the services provided at MAH. This response did not tell me very 10:29

much, nor did it address my concerns.

I took my concerns to my local MP, Gavin Robinson, which led to a meeting at DUP headquarters and this was attended by Gavin Robinson, Chris Matthews, Director of 10:30
Learning Disability, Department of Justice, Mary Heaney, Director of Adult Social and Primary Care and Sean Holland, Chief Social Worker NI. Important concessions were made at this meeting by Sean Holland and Marie Heaney. I refer to my handwritten notes from 10:30
this meeting at Exhibit 17.

BHSCT has repeatedly failed to involve me in their internal adult safeguarding referrals and investigations. I have never attended any adult 10:30
safeguarding meetings with the BHSCT to discuss any allegations of abuse on the CCTV footage.

In October 2022 I contacted Chris Hagan, the medical director of the BHSCT. I was attempting to find out 10:31
the outcome of the adverse incident process whereby P96 was able to repeatedly escape from his ward in MAH in December 2018. P96 was located in the MAH car park at least ten times in one day. I am unsure if these were classed as separate incidents or if they were 10:31
categorised as one adverse incident. As I was not contacted by anyone in relation to the adverse incident process I decided to submit a formal complaints about the incidents of my son being found in the MAH car

park. I have still not received a final written response to my complaint almost six years after submitting it. My complaint about the adverse incident was discussed for several months at the monthly MDAG meeting. I always found this to be a confidentiality breach because the minutes of the meeting were a public record. 10:31

I received a holding response on 31st October 2022 from Chris Hagan in which he apologises for not being informed of the incident. 10:32

I eventually received substantive correspondence from BHSCT dated the 18th January 2023. This correspondence did not address any of the issues which I had raised in my correspondence to Mr. Hagan. In this correspondence BHSCT advised that during P96's time in MAH there were eight adult safeguarding referrals, seven of the eight incidents related to peer on peer incidents and these were dealt with solely by BHSCT as single agency matters. All eight adult safeguarding referrals are now closed. I never received the details, information or paperwork relating to these safeguarding referrals. 10:32 10:32

Since P96 was admitted to Praxis Community Care there have been four allegations of abuse. All four have been handled appallingly. Of the four referrals two adult protection investigations commenced which would result in a draft investigation report. The allegation of abuse from the 24th May 2021 is still open. It is 10:33

unclear why this investigation was seemingly abandoned by BHSCT and not closed by the designated adult protection officer. The allegation of September 2022 remains open and at this stage it is unclear why the investigation has taken over one year to complete. 10:33

My son receives excellent care at Praxis but he remains unsafe because the BHSCT adult safeguarding process is not fit for purpose. I echo the comments of the NI Public Services Ombudsman who said on 7th June 2023 10:33 that adult safeguarding is not fit for purpose. There were some individuals who properly cared for P96 and I feel that it is important to also recognise this. I consider the process of obtaining information very stressful to try and navigate and not fit for purpose. 10:34 To this day I am still battling to get information and numerous investigations remain outstanding. In my view MAH constituted a massive scandal and the authorities would do all they could to avoid and cover up as much as possible. I understood a whistle blower was 10:34 involved and determined that the truth should be brought to light and those responsible, especially at the senior levels, exposed and held accountable.

At a meeting on 17th December 2018 Richard Pengelly, 10:34 DoH's then Permanent Secretary issued an apology to the families of patients at MAH. The DoH issued a statement that same day announcing that Richard Pengelly had apologised to families at a meeting which

cited his firm commitments. In this statement he said that he expected the resettlement process to be completed by the end of December 2019 and that he fully recognised the deadline for the resettlement process would be challenging but the DoH owed it to patients and their families, I attach a copy of this letter at Exhibit 18.

P96 got out of MAH on 21st February 2020. I believe that the relative ease with which I was able to get P96 out and resettled in a Praxis apartment was more to do with MAH wanting rid of me as a thorn in their side. I also have concerns about P96's detention status whilst in MAH. During the first five or six weeks the staff would have commented how P96 was very good and had no adverse behaviour. However, after a while our family were told that he did have some behaviours and that he had been sectioned. Subsequently Dr. H30 told me that they had lifted the section as they had decided P96 did not have the ability to escape. P96 clearly did have the ability to escape given what happened when they moved P96 from PICU to Cranfield 2.

A couple of months later Dr. H30 then told me that P96 was to be sectioned again. This was, she said, because it did not sit well with her to use force or seclusion on a voluntary patient. At the time I did not appreciate the significance of P96 being voluntary or detained. When P96 was sectioned I thought this was the procedure for getting him the treatment he needed.

In hindsight for me, the reality is that when P96 was sectioned I lost total control, MAH made all of the calls.

I attended one Mental Health Review Tribunal, MHRT, for P96. I got a letter to attend and brought a solicitor but from my point of view it seemed to just be a routine. It did not last very long. It just reaffirmed that P96 had shown aggressive behaviour and that he was getting treatment, and asked whether we agreed. Our family agreed that P96 needed treatment and so we agreed. In hindsight I am unhappy with this system. I came from a background of knowing nothing about the procedures and I felt that I was thrown in with no idea of what was appropriate. I feel that it is important that people in this position have an advocate who can give proper advice, someone with experience and not just someone who is there to hold the ropes. I am greatly disappointed by the lack of direction, knowledge and procedures shown to the PCC and their failure to help me with the complaint. It was clear to me a female member of staff did not grasp the complexities of the case and I was subsequently informed that she had left the PCC. I was told that Viviennne McConvey, Chief Executive, would take over my complaint but this did not happen.

My experience has prompted me to help form the Action for Muckamore Group in 2020 in order to assist others

in the same position as my family. I have spoken to so many families who faced issues just as we did and had little or no support.

The way P96 and other patients were admitted and detained was an irregular manipulation of the procedures and I would like the Inquiry to investigate that as it would seem to bear no resemblance to the systems that I now understand have been carefully put in place to protect vulnerable people. I would like the Inquiry to investigate what the current systems and procedures are for the admission and detention of patients. 10:38 10:38

During his time in MAH items of P96's property would have gone missing, for example I bought P96 a new coat for his birthday and it went missing almost immediately. I raised this with H397 but nothing seemed to be happening. My social worker advised me to bring a receipt for the coat into MAH. I did this and gave it to someone in PICU. Eventually I got the money back for the coat, but it took a long time. P96's grandmother also bought him an expensive cardigan with foxes on it and it went missing too. I also bought P96 a Gillette razor and blades but a couple of days later a nurse told me that P96 needed new blades as the blades which I had just bought had gone missing. 10:38 10:38 10:39

When things were left in they should have been itemised

but this did not happen in MAH, there were no records. I would like the Inquiry to investigate the whole way in which patient's money and other property has been handled over the years. I am aware of many families who provided money over the years in the belief that it was being used for extras to benefit their loved one, in addition to the benefits to which they were entitled, but who failed to receive any account of what was done with it. I would like the Inquiry to find out how management could fail to put in place a proper system of oversight to ensure not just the patients money was handled properly and accounted for, but that their possessions were treated with care. Clothing and other items were often gifts that needed to be respected. 10:39 10:39 10:40

Whilst our family have been told that those involved with P96 had been suspended, we have no way of checking because no one has been identified to us. This is a concern should P96 ever have to attend MAH again. 10:40

My main concern is to expose what I believe to be the scandalous failures and cover up by more senior management in BHSCT over many years. I believe that their reaction to this scandal was lethargic and incompetent. I believe there was a lack of cooperation by senior officials with the Leadership and Governance Review. I would also query whether the fact Michael McBride held two senior positions at the time, that is 10:40

as chief executive of BHSCT and chief medical officer, contributed to a failure to keep proper scrutiny and governance.

There were also senior officials who did not cooperate with the Leadership and Governance Review. It seems completely unacceptable that they were allowed to avoid this. These people should now be called upon to explain their role and their failures and to answer the relevant questions that were unanswered concerning CCTV et cetera. 10:41 10:41

As to the investigation of the allegations of abuse, I would like the current joint protocol scrapped as I consider that it has done a severe disservice to patients. I would like the Inquiry to recommend that and require that a better system needs to be established in collaboration with families and carers that makes proper provision for their involvement. 10:41

I believe there is a therapeutic intervention that may be appropriate for P96 but that BHSCT have not provided. I would want an independent report as I have absolutely no confidence in anything carried out by BHSCT in relation to P96. 10:41

I would like the Inquiry to recommend that BHSCT provide for an independent assessment and, where required, appropriate therapeutic support for patients

and former patients.

I am also concerned that P96's repeated escapes from Cranfield 2 after his rapid move from PICU and all associated issues. I consider that these need to be properly investigated so that appropriate procedures can be put in place. 10:42

My view is the Inquiry must get to the bottom of all these failures from MAH management, HSCB, RQIA, BHSCT officials, the lies that were told about CCTV, the Ennis Report, SAI and adult safeguarding failures. It will also need to address the impact of the trauma on the patients and the extent to which the diagnoses and prescribed medication are correct and appropriate. 10:42

I have concerns relating to the overuse of PRN medication as an early rather than last resort. I am unaware of whether there was any protocol in place for the use of PRN medications. I am also concerned about the use of Olanzapine. I am particularly concerned to establish whether P96 was subjected to any form of experimental drugs or drug regime while in MAH. Sometimes when I went to visit P96 his pupils were massively dilated. His medicines were stopped, chopped and changed but at the time my view was that P96 was in hospital, the doctors were the experts and I could not challenge them on this. 10:43

I know of so many relatives concerned about the medication their loved ones were put on whilst they were in MAH and the use of PRN, which in my experience with P96 was rarely as a last resort. This is an area that I would like the Inquiry to give a special consideration as in my view P96 and many others may still be suffering the effects of inappropriate medication which itself was a form of abuse. The Inquiry may even consider it appropriate to require BHSCT to offer families and carers an independent review of the medication regime of their loved ones. 10:43 10:44

I have grave concerns over the medical treatment of P96. P96 went to MAH with a small verruca on his foot, however he left MAH with four large verruca on his foot and his hands covered in warts which had to be burnt off in his GP treatment room. 10:44

P96 required one on one supervision during meals. I am very concerned at the fact that BHSCT acknowledged in their letter from the Chief Executive dated 3rd November 2017 that there were neglectful practices, specifically the lack of meal supervision. 10:44

I am also concerned about the complaints process. I believe that the Inquiry might consider recommending that an aide-memoire or similar simple document should be available to families explaining the process. I feel that this is particularly important for people 10:44

from a non-mental health or learning disability background who are unsure about what is proper or appropriate. My problem is that when I brought complaints I would be asked did it get recorded in the journal? No. Was it raised in writing? No. Are there photos? No. And then my complaint was not given any credence. I believe that an aide-memoire could provide a starting point for families so that they know what to do if they come in and find that their loved one has bruising or something similar. I believe that the aide-memoire could set out a guide to making an effective complaint. I believe that this could help to ensure that complaints are given more credence. 10:45 10:45

I am of the view that the Inquiry should also make an interim recommendation that CCTV be installed in all resettlement placements or facilities. This could reduce the incidents of abuse, assist in understanding how patients engage in self-harm while protecting staff who may be subject to patient on staff assault. The Inquiry should consider recommending that this CCTV is installed throughout the premises and not the common areas as the experience from MAH has been that the reach of CCTV is well understood by those who engage in abuse. I understand that the CCTV footage is overwritten every three to four months depending on the level of activity in the area. The Inquiry should consider as part of an interim recommendation when this is sufficient to provide a suitable level of 10:45 10:46 10:46

protection. I also think that body worn camera devices should be mandatory for staff.

In my view what happened at MAH was not only a massive abuse scandal but it was also a disgraceful cover up by people in authority. In my view it is essential that the Inquiry addresses both the abuse and the cover up."

Now, P96's Father, you have been listening to me for quite some time? 10:46 10:47

A. Yes.

12 Q. That's obviously only the part of the statement that is not subject to restriction.

A. Yes.

13 Q. I recall that you wanted to correct something in paragraph 14 where the sentence reads: "The social worker H580 was very aggressive" and you're saying that in fact that's not the case? 10:47

A. Absolutely not, we relied very heavily on her advice and expertise. Again, she did continue to perform a section over our heads but she definitely wasn't aggressive. We actually relied on her very heavily. And also I made a wee note there on paragraph 108. 10:47

14 Q. That's what I was going to ask actually, whether there were any other points in the statement, in the open section that you want to draw the Panel's attention to? 10:48

A. Paragraph 108, it wasn't my complaint, there is no photos, there is no corroborative evidence. What I was saying for people making a complaint in general, when I

asked different members of the group did you get that in writing, no, did you take photos of any alleged injuries, was it reported to management, no. I wanted an aide-memoire for people that have no experience of making complaints, that they would have a proper and authoritative guide on how to do a successful complaint.

15 Q. When you are talking about the group, I take it you are referring to Action for Muckamore?

A. Yes. 10:48

16 Q. That group would bring you into contact with many patient's relatives presumably?

A. Yes.

17 Q. So just to make it clear in paragraph 108, that is not personal experience, that's your experience of what people are telling you? 10:48

A. What everybody was saying, yes.

18 Q. I just wonder apart from those two matters was there anything else in the statement?

A. That seems fair enough, yeah. 10:49

19 Q. So you are content with that and to adopt that as your evidence?

A. Yes.

20 Q. Now, it's a very detailed statement and I am not going to go back through it all. I am just going to start by having a look at the photographs you have provided the Inquiry with, P96's Father. You've given us I think four photographs? 10:49

A. Yes.

21 Q. I wonder if we can just show those on screen, please, you can talk us through them if you like, P96's Father. What age would P96 have been in the first one?
A. P96 is, that's probably about four months ago.
22 Q. And what age is P96 now? 10:49
A. 26, 27 in November. Why I used those, that would be taken by staff in his facility.
23 Q. Yes?
A. If you notice P96 is smiling there. Now, it could be P96's birthday, I could say smile, he won't smile. He 10:50 only smiles when he is happy.
24 Q. Yes?
A. The staff, he has an excellent team around him to be honest, very, very good. They would take him out on outings and they would use SeeSaw, one of the apps, and 10:50 take photos and then send them to you, look, we at the donkeys, we are at the seaside or wherever and they take photos, invariably he is smiling in the photos.
25 Q. They have certainly captured the smile in that first one, P96's Father? 10:50
A. Yes.
26 Q. What about the second one?
A. That's the old Folk Park Museum. And again it captures the interaction between him and his carers. You can see him looking up very smiley. 10:50
27 Q. How old is that photograph?
A. That one there is probably about five, six months ago.
28 Q. And those carers are from his current facility?
A. Yes.

29 Q. And then the third photograph is on the swing?
A. That's on the swing during the summer. He loves the swing.
30 Q. Just summer past?
A. Yes. 10:51
31 Q. And then finally we have?
A. Eating ice cream. That's out near Portrush I think, or else it was Ballyholme, one of the two. But the bottom line is, you know, again you can see the smiles, very happy, content, interacting with those looking after 10:51 him.
32 Q. Yes. Those are very recent photographs. I want to go back in time and in your statement you talk a little bit about P96's time growing up with the family and at school and I just want to pick up on a point that I 10:51 focused on in your statement when you suggest that the facilities that P96 attended when he was a child catered reasonably effectively for his needs; is that a fair point to make?
A. Yes, you see, he went to a special school and you get 10:51 to know the parents, you get to hear their problems, their difficulties. And the common theme, which we didn't appreciate at the time, was while he is a child there will be provision, there will be respite, there will be all these different things for him. But once 10:52 you become an adult, it just drops off a cliff. Now he stayed lucky enough due to his birth date until he was 19 nearly in the special school. But, once you left, I mean a simple example was once he left he was meant to

go to a five day placement in Edgcumbe and the first thing, no, we can only give you two or three days, so I had to go to Gavin Robinson to make a complaint to get that actioned. So you found anything to do with kids with special needs, even from birth, you know, when he is four or five years old, my social worker who has now moved to England said I'll put in for DLA, I put in the forms, done them. I was turned down on both the care and mobility part, zero. She was very cross at that, she said half this country is on DLA, shouldn't be on it. She says there is somebody that genuinely needs it, can I do your appeal. I says fill your boots. So she done my appeal and he got top rating in both. You went from being awarded zero on both, somebody does an appeal for you, you get top rating on both. Everything you find with kids with learning difficulty, it is an uphill battle. And respite when P96 was an adult was very complex, you know. There is facilities that project themselves as experts and they are maybe not as expert as they think they are. 10:52 10:53 10:53 10:53

33 Q. Did you find the quality of facilities for children better than for adults?

A. Yes.

34 Q. Why exactly was that?

A. There were, I don't know whether it was that you are able to cope better, or a different mentality. He was in a place in Dunmurry, Lindsay House, now at the start to be honest we were very reluctant to put him in. He had never been away from home so we were scared to put 10:54

him into the care of people who you didn't know, even though you knew they vetted et cetera, but it still was a big chance you were taking putting him into care. So sometimes he acted up, you are meant to go in this date and we would have reneged at the last minute. In the end they said you have to avail of the facility. We sent him there and very quickly he adapted, he liked it. It gave you one or two nights breathing space and it was very good. But when he became an adult, you know, it was much, much harder to get a facility and a facility that could cope. 10:54 10:54

35 Q. Yes.

A. You know, the same when he went to Torbank School. Once I sent him on the bus I forgot about him until he returned home because they coped with absolutely anything. They can take complex kids, their staff just got on with it. You found in an adult setting with respite that people are not as robust, I don't know, sometimes I get the feeling -- 10:55

36 Q. Now when you say people are not as robust, are you referring to the staff? 10:55

A. Yes, so what I think is a lot of places are looking at somebody with say Downs Syndrome who is sociable, affable and he is easy to control. Where if they get somebody who has maybe autism, they can have outbursts, maybe not as keen. I understand, you would rather have three quiet people than three people who are complex and problematic. So that's what I find, that once you are an adult. And it is probably the system too, if 10:55

you are complaining about something there will be sympathy, if you say a poor disabled child is looking at A, B, and C. But when you are an adult, you know, there seems to be a different attitude.

37 Q. I just wanted to talk a little bit about P96's admission to Muckamore. The first issue that you raise is that you weren't really given a full and proper explanation of what it meant to be detained under the Mental Health Order. This is very difficult but looking back with your knowledge now, how do you think communication with you and your family could have been handled more effectively? 10:56 10:56

A. I am scared to answer that due to what I know in case it borders on restriction. I will give you an example, when he was going into Muckamore my perception, because I have nobody in my family has learning difficulties so I wasn't aware of any facilities. I had seen Muckamore photos in the past years ago and it would have reminded you of Crumlin Road Prison, a victorian, grim looking place. I was thinking my God, how could we put him in there. My social worker went and got photos, brought them home and says look, there is the photos, it looked like a modern holiday village, open greens, rabbits running about, so it looked like a modern facility which was quite comforting. We were worried that he had never been away. We were always taught they need stability, same people, same routine and I am going you are going to section, put him somewhere he has never been with staff he has never worked with, with regimes 10:56 10:57 10:57

he is unfamiliar with. I was worried that was massively destabilising effect on him. I wasn't told anything about the place. Now what I was told this is the jewel in the crown was the phrase used. It is the most highly staffed, highly trained unit in Northern Ireland, it is the regional facility, this is the place to go if you have got a learning disability and there is a crisis in the family.

38 Q. You just mentioned the point about P96 being with staff that he wasn't familiar with, was there any attempt before P96 went to Muckamore to ensure that he knew the staff that would be working with him? 10:58

A. No. The problem was it happened so quickly. Once, you see my problem was in my house at the time my youngest son was 14, in law a child. Now in reality he is my stature, he's big, he is a bear, he had a full beard at 14, rugby player, he is hard core. But we were getting bit all the time, P96 attacked us on a daily basis. The social worker sort of -- if we get bit that's acceptable but it was made quite plain to me if my youngest son gets bit or injured, the fur will be flying. So in incidents you had to watch, he would have responded. You also went [name] watch out, P96 is biting all around the place, if you get bit here we'll never hear the end of this. I will give you an example, one night, everybody would lock their bedroom at night, all you would hear is click, click, click. P96 would sleep with me and that was just the way it was. But, in the middle of the night he attacked me. 10:57 10:58 10:59 10:59

I slept with paint ball gloves, you know with the reinforcement down the fingers. So I ended up with a wrestling match in the dark trying to get the door shut. So I pulled the door, got it shut and locked it, that was close and he bit me on the arm. I told the social worker, I says look, a bit ropey, he attacked me in the middle of night. What did you do? I said we had a wrestling match and I eventually got the door locked and locked him in for 10 minutes. Don't be admitting you locked him in the bedroom. I said what do you mean, I said he was going to eat me. And she says no, God, no, you should have wrestled him out onto the landing and locked yourself in the bedroom. I says well what difference is that? Well then he could run about the house, access the fridge, drinks, toilet. I says look, this is real world, in the middle of the night in the dark I'm not going to wrestle him at the top of the stairs, he goes down the stairs or I go down the stairs, it is what's realistic in the real world. Like I checked him after five minutes. So those pressures were on you as well when you were dealing with this. 11:00 11:00 11:00

39 Q. Can I just come back to when P96 was actually admitted to Muckamore. I think you said at the time you expected it to be a short stay? 11:01

A. Yeah, we were told, we were totally against a section but we were told look, it will only be for six weeks. Now we went, you know, that's a long time for P96 to be away from us so we were deeply unhappy with that.

40 Q. Because I think you give the minutes of one of the meetings in your exhibits, we needn't go to the exact page, but your wife asks how long P96's stay would be likely to take and you were told it's a shorter rather than longer admission? 11:01

A. I remember that.

41 Q. There will be a plan for discharge in the summer. So at the start you were expecting the stay to be fairly short one?

A. Yes. 11:01

42 Q. But I also want to ask about the actual admission itself because you say you had concerns about the admission process?

A. Yeah.

43 Q. You set those out in your statement and I think you refer to -- 11:01

A. I felt it was coercion. I will give you an example, once they brought everybody, social worker, psychiatrist, everybody came back once that incident happened and they went through the process. When they left I said they were trying to section him, she says no, they weren't. I said they were trying to section him. So on Monday the social worker came back and said we are minded to continue with the process, what about t hat? I says talk in plain English here, you are going to section him over our heads, isn't that right. She says oh no, don't be saying I am doing this over your head, we are doing this together. Said I don't want you to think it is us against you and P96. I 11:02 11:02

understand where she was coming from but what was explained to me was this process will be ongoing and if you fight it, because I had already been on to my solicitor, he says I will hold these ones off easy for three or four weeks, but they are going to say you have 11:02
a child in the house, even though he is a bear, they are going to say you have a child who is vulnerable. They are going to get an independent social worker, independent doctor, independent consultant and when they win, he says the police will come and take him in 11:03
a car. And we thought flip me, we couldn't have that. But they told us, the social worker told me everywhere is full, if you voluntary section him we'll clear a space in Muckamore and put him in there. If you don't, whatever day it goes to court and they win, he'll go to 11:03
the available facility, should it be Londonderry, Armagh or wherever.

44 Q. So are you saying the admission process was shortened by accepting that admission should be voluntary?

A. Yes, but it was blackmail, coercion. 11:03

45 Q. I want to ask about the other point you make about the apparent lack of a clear plan?

A. Well, what actually happened once it became a bit farcical because the plan was to put him in on a given date and then the social worker told me look, they 11:03
can't clear Muckamore as quick as they thought they could, fair enough. She says the problem that gives us is P96's been identified as dangerous, a young child in the house and if anything goes wrong in the interim

until he is sectioned, you know, there will be bad consequences, you know, she says we'll never hear the end of this. So they brought out the consultant and it was a bit farcical, you know, he says right, in the meantime as a mitigating factor we can increase his meds. And he said to me do you have a plan? I says plan for what. He says if P96 kicks off. I says there is no plan, I says depending where it is and who is around you have to manage him, grab his hands or hold his head and get everybody out and sort of withdraw when it is safe to do so. 11:04 11:04

46 Q. Are you saying you were asked for the plan?

A. I was asked for the plan.

47 Q. But you were expecting the plan to be produced to you?

A. I was expecting here, I have dealt with 100 kids like this and here is my experience of what may be good. There was none of that, what is your plan. 11:04

48 Q. In fairness I just wanted to look at the actual, the very early days in the hospital. If you go to page 33, it's the minutes of the best interests meeting on the 13th June 2017, page 33. The top, you see those page numbers at the top, those are the ones I am working from? 11:05

A. 33, yes.

49 Q. And then you'll see under "ward update", so that was a meeting on the 13th June at the hospital. 11:05

"Doctor H30 spoke of how lovely P96 is and how she warmed to him immediately. H16: P96 is doing well and

has settled in well to the ward environment. There are very few incidents of agitation and aggression. P96 continues to be vocal on a daily basis. He is eating, drinking, and sleeping well. He enjoys attending day care and gets on well with his day worker." 11:05

Then there is a discussion about the medication. Is it fair to say that those early days appeared very successful?

A. Yes, we were told at the start there was no adverse behaviour. What's he in for, he is a wee lamb. We went, right, because he certainly wasn't like that at home. 11:06

50 Q. And what about, what was your impression of the hospital in those very early days?

A. Very early days, bearing in mind my perception was a Victorian dungeon place, this was more a very bright, roomy, modern looking holiday village, there was rabbits running about the green. There was a lot of female staff, which I liked, because, you know, generally speaking female staff wouldn't be as aggressive as the males. Logically speaking if anything went wrong I was thinking with so many females, if anything untoward happened it's more likely to be reported, which was a big mistake. Again, another part to that was I said to my wife, some of the females were very petite, very slim. I used to say if he kicks off how is A, B, and C going to manage him. 11:06 11:06 11:07

51 Q. You thought there might be a difficulty in physically managing P96 at that stage?

A. Yes, yes.

52 Q. What about the staff, did you have much dealings with them at that time?

A. No.

53 Q. Did you have a go to person that you could speak to? 11:07

A. Not really. They had a named nurse but it wasn't a go to person. If I was dealing with anything it was who is available on any given day, I would just speak to that person. I wouldn't actually say is so and so on, until much much later when I got to know certain staff 11:07 that I would have had trust in, I would have made a beeline for certain ones.

54 Q. In your statement you refer to one positive, what appears to be one positive aspect of those early days which was that staff managed to get P96 off sleeping 11:08 medication and managed to control his ADHD?

A. P96 was on Phenergan which was quite a heavy sleep med, he was on four or five mil spoons. At home if you didn't give him that he wouldn't have went to sleep, he would have been bouncing about. He was very 11:08 hyperactive. In Torbank they called him Tigger, the other kinds, because he continually bounced. You know, he could have run about until 3 in the morning, conked out for one hour and then back up wanting to play an hour later. So once you gave him four spoons of 11:08 Phenergan, it would have half an hour later knocked him out and he would have generally stayed asleep for six or seven hours, you would have got a half decent night's sleep. They got him off that which to me was a

big thing because that is a heavy medicine. They also changed his ADHD meds. They told me, I remember they rung me, we are taking him off his ADHD meds. I told the wife, watch this, he will be back on them tomorrow morning. They rung me the next day, that's wild, he is bouncing around the place. But they were able to tailor them, instead of bouncing morning, noon and night, people say let him bounce, he will tire himself out, he doesn't and he will pull the arms off you. They actually got him where P96 would take your hand gently and walk you room to room which to me was massive, if you understand that was a massive change. 11:09 11:09

55 Q. In fairness that appeared to be a positive step?

A. Oh, absolutely.

56 Q. I am going to skip forward, P96's Father, to the period of time after P96 moved out of PICU and into Cranfield 2? 11:09

A. Yes.

57 Q. Which was a move from a closed environment to a more open environment? 11:09

A. Mhm-mhm.

58 Q. I think that was in or around December 2018; is that right?

A. Mhm-mhm.

59 Q. Just to pick up on something you say in your statement about there being no social story to prepare P96 for the sudden change in environment, what do you mean by that? 11:09

A. Well, in other places, they always taught you with the

likes of P96, in Torbank they tried Makaton, picture exchange, Toby. His teacher went to the most experienced teachers in the facility and says we are trying to communicate with P96, he is non-verbal, have you done Makaton, have you done Toby, done picture exchange. They tried every trick in the book and nothing worked. So if you are preparing him for something major they would say give him a social story, show a picture. Say if you are going from my house to another place, if you have photos of it, look P96 house, photo of the car and a photo of the venue, so he could start processing what's going on. But, that night of the move I got a phone call at night from H50 and he gave me this rigmarole. He said look, we are thinking of moving P96 to Cranfield. I says is this a courtesy call or is this a call looking for permission, are you actioning this whether I agree or not? He says well it's going ahead in an hour's time. Right. So PICU, he is well settled, it's a closed ward. If you move him to Cranfield, it is an open ward, he will escape. Now at this stage I was worried about him escaping. I didn't realise, I didn't have access to his notes, I didn't realise he has been doing that on a protracted basis, intermittently. So I was thinking there is a danger he may escape. I said P96 has a history of choking and I says the staff should be well versed in feeding plans, et cetera, and when he moves to another ward you will be different staff and you are then going to be back to the opportunity for staff

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being unaware of his feeding plans, et cetera, et cetera. He told me no, no, he says it has to happen. I says look I want a one to one, a special as it's called. He gave me a fancy name for it, like workforce planning, we'll get them to phone you. My plan was if they are going to move him put somebody one to one for his safety. That night I got a phone call, a member of staff moved him from PICU to Cranfield and he is in bed asleep. They said it is such and such a time, 8.30 at night, the mag lock comes on and the door is locked so he is safe until tomorrow morning. I was very unhappy about that because I could see the dangers presented. I rung the Irish News and said look what is the score here, what is going on. She made calls and says oh, it is a staffing crisis, due to events unfolding in Muckamore, certain staff have got wind of what's coming and a load of people have went sick. The fact is they can't meet their care plans. Now, the strange situation for me was, and I can understand the rationale, what I was hearing was we'll close PICU because there is only six patients and the biggest intensity of staff and we will put them to the four winds and that will release the greatest amount of staff. But as I said in an ordinary hospital if you are short of staff you wouldn't close your intensive care unit just because you have one to one or two to one nursing on each patient. But that seemed to be expedient up there.

11:12 11:12 11:13 11:13 11:13

60 Q. Coming back to P96's particular situation, I think, is

it fair to say there are a number of things you were concerned about. First of all there wasn't a proper risk assessment conducted before the move?

A. Yes, I was on the union, I've done [Inaudible] so I was rationalising things so when you've moved him, a change of practice, there must be statutory risk assessment to identify inherent risks and put in proper mediation measures to mitigate that risk. So when he escaped I then asked where's the risk assessment, did you do one? Yes. Right, I says well can I see a copy of it please? Yes. So it will waiting for you when you come up on the next visit. I am looking for the risk assessment, I know nothing about it. Then I got a call from a charge nurse, I'm not mentioning names, I've to give you a risk assessment, what's this about. I says right, I already had sources up there, I says tell me, you were in the pub at the Christmas dinner with your colleagues on the night P96 moved, isn't that correct? Yes. Well then you can't be doing the risk assessment, you were down with all them. I says that's fair enough. Oh, you want the risk assessment that nobody done? Yes, that's the one. 11:14 11:14 11:15 11:15

61 Q. Ultimately it was accepted that a risk assessment hadn't been conducted?

A. Yes, but that was only after they lied and lied and lied. I says right, I have had enough of this. I went to the Health and Safety Executive and I says my son has absconded, and they haven't done a risk assessment or they have identified the risk and the fact they 11:15

haven't been able to produce it. So eventually it was me that brought the health and safety executive into this. He came up, made them do a risk assessment, made them make different amendments to it. He says there is one now for a patient absconding. I said that's good, now I want you to do them, that's a statutory obligation, I want them prosecuted. He said no, they didn't have one, then they got one. Your argument is now with them, that they didn't have one. 11:15

62 Q. But ultimately it was accepted that there hadn't been an assessment done? 11:16

A. There hadn't been one.

63 Q. The other thing that you were concerned about, correct me if I'm wrong, was that you weren't being informed about the number of occasions on which P96 escaped? 11:16

A. Yes. So I was so cross that when I met P96 in the car park, you know, this was December 22nd, it was freezing, I mean bitterly cold. He is running about in a dressing gown, no socks and shoes, no trousers. My son, my youngest son was up with me to visit him. I said are those eejits letting him out for a walk dressed like that. I says say nothing, I will do all the talking. I said excuse me, are you talking him for a walk? 11:16

64 Q. P96's Father, I am asking you do one thing and that is to slow down slightly because the stenographer is taking a record. 11:16

CHAIRPERSON: I am also just thinking about timing because we have been going an hour and a quarter with

this witness and that's a very long time for the stenographer to go. Have you got a plan as to how much more of this section of your examination?

MR. DORAN: I would like to think about 15 to 20 minutes more in open. 11:17

CHAIRPERSON: Right. I think we had better stop there.

MR. DORAN: Closed should take approximately an hour, an hour and 15 minutes, Chair.

CHAIRPERSON: Right, I think we had better stop there because the stenographer has got a very long day ahead of her. 11:17

A. You see there is valid points in that, in the fact that he spent the day escaping and I was officially told he got out three times, which I knew was incorrect, which was one of the reasons I wanted the full day's footage to establish how he was dressed, how soon he was out, how quick staff responded and all the associated issues. 11:17

CHAIRPERSON: I understand that. We are going to come back to that topic I imagine when we resume in about ten minutes time, but we need to take a short break now. Okay. 11:18

CHAIRPERSON: 10 minutes.

THE HEARING ADJOURNED. 11:18

THE HEARING RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you. We'll try now to keep going

until 1 o'clock if we can. But, I'll say again, I said privately to the stenographer, if you need a break please just wave a hand and we'll stop. Okay, yes.

65 Q. MR. DORAN: P96's Father, in relation to the issue of P96's escapes when he was at Cranfield 2, you have engaged in lengthy correspondence with the Trust, it's fair to say? 11:39

A. Yes, still ongoing.

66 Q. And you exhibit a lot of that with your statement?

A. Yes and there's more to present. 11:39

67 Q. I am not going to go into it all in detail, you have provided it to the Panel. I want to ask you a few questions about it. One point that the Trust make in the correspondence is that when P96 left the ward there would have been a member of staff on hand to observe. 11:39 Has that calmed any of your concerns about what occurred?

A. No. My problem is I requested full day's footage. They provided the morning footage. Now their letter to me was oh, you subsequently looked for the afternoon 11:40 footage. That was not the case. From the very outset I wanted to establish how many times in the duration of the day he got out, how was he dressed, how quick did staff notice he was gone and all associated matters. So I was expecting, as she played the videos, and says 11:40 there he is out again, there is him out again, until I arrived to take him out for his dinner. So at that stage there was 11 or 12 escapes. I says that's interesting because your boss said there was three and

she was a bit perturbed. I said play on to get -- I didn't know you wanted the afternoon. I said what part of all day is not the afternoon? She says I have to go and pixelate it, fair enough.

68 Q. Again, P96's Father, just slow down slightly to help the stenographer? 11:40

A. So I told my social worker, I said to, what do you call her, H580, she was out visiting me, I said I am getting my eye wiped and I can't understand how they are going to do it. She said to me, no, they've told you, they are going to pixelate out the footage and you are going to be provided with it, so you just have to sit tight until the footage is ready. I says no, I am getting my eye wiped and I can't work out in my head what's going on. Subsequently then they came back and said somebody has deleted the footage. 11:41 11:41

69 Q. So the afternoon footage?

A. Got deleted.

70 Q. Was deleted?

A. Correct. 11:41

71 Q. Again I am not going to go into the full detail, but more recently in January of this year you received a 17 page letter from the Trust; isn't that correct?

A. Yes, yes.

72 Q. And that's exhibited at Exhibit 9 of the papers. Now, again, I am not going to go into the detail but it does appear from a reading of that, that the Trust would like the matter to be drawn to a close at this point? 11:41

A. I can understand because the leadership and governance

review wanted all these matters resolved. It's inconceivable that we are coming six years into a scandal and you're still trying to resolve issues.

73 Q. But that particular period in Cranfield 2 still causes you a lot of concern? 11:42

A. Yes.

74 Q. Isn't that fair to say?

A. I still haven't got to the bottom of what happened and then they deleted the a.m. footage and wanted to do an investigation. So I said do you want to do an 11:42 investigation once you have deleted all my proof? I says give me, you've already admitted that The Family Liaison Officer, I don't see her name there, that she had made notes because I asked as well as showing me the video she had made notes, there is P96 getting out 11:43 at 9:50, 10:00, 12:00 and she had made notes. I said I want her notes because that would have proved the time he got out in the morning and I wanted recovery software on her computer, her laptop, and also on the system. But of course they claimed they can't do 11:43 either.

75 Q. So far as you're concerned the analysis of that period remains a live issue for you?

A. Yes.

76 Q. I mentioned the complaints that you've made in that 11:43 context and it's fair to say that you have raised issues concerning your son's care with all of the relevant authorities?

A. Yes.

77 Q. And you give considerable detail about that in your statement. You talk about contacting the Trust, the ICO, the Human Rights Commission, the RQIA, your local MP. As I say I am not going to go into those in evidence. Just as regards the Trust itself, did you have an awareness of the complaints process, was that brought to your attention? 11:43

A. No. This is the problem I found with the whole system. For instance, you would get the PCC now as an advocate and my experience of them, I think they are abysmal. 11:44

78 Q. On what basis do you say that?

A. I wanted somebody out to help me make a complaint so they sent me out a young lady. I says my son is in PICU, Psychiatric Intensive Care Unit known as PICU. I gave her a rough outline of what I was trying to achieve and what happened. She sent me a draft letter and said "P96 is in P.Q.". I went I have sat with you all morning telling you a story, I have even elaborated on what the initials mean and clarified it and you give me a letter which if I put in would make me look like a chimp. So she disappeared into the woodwork. I didn't hear from her for weeks. I was worried that there would be a time band on how long a complaint has to be before it's delivered. So I rang up the PCC, I don't see her name here either, a very senior person in the PCC. I says listen, I had a young female out was helping me with my complaint. Hold on while I check my system, that was so and so. Right, well where is she? Oh, she's left the organisation completely and moved on 11:44 11:45 11:45

to further employment. Right, well she was helping me with my complaint and now it's up in the air. Don't worry, I'll do your complaint for you. Brilliant. So, this senior person said she would then action my complaint. That was the last I heard of her too. Then in the meantime I found somebody who knew the procedures, thank God, and that's then when --

79 Q. What organisation was that person with?

A. That person would just be someone with interest in learning disability. This person would help people on an ongoing basis, was involved in a different campaign group, we met through the other campaign group and got to know each other. He was explaining to me, I understand the adverse incident procedure, you need to ask for this, you need to ask for that. That is when you will notice a change in my e-mails, they become really pointed. Ask for this, as for the APP1s, as for investigation reports.

80 Q. Yes, was this person an independent advocate? I don't think there is any issue about naming them if you wish.

A. I don't know if I have his permission.

81 Q. Very well, perhaps it's best to proceed with caution. But was their role that of an independent advocate or something like that?

A. No, just somebody who would help people. He goes out of his way to help people with learning difficulty problems across a wide range of issues. The best thing that happened because he knew the system. This is my point on advocacy, I don't want somebody to sit and

hold my hand, that doesn't interest me. I want somebody that knows the intricacies of the processes, the systems and what I should be asking for. Because once you started asking detailed questions, then you found out you are not going to get answers because we are open and transparent, that's the wee phrase they use, which cracks me, because they are the exact opposite. So I have a chain of e-mails back and forward, back and forward. Simple things, regional policy came in 2015, the Adult Protection Procedures came into force in 2016 and yet the Trust didn't have it implemented on their system for six years. And recently it was showing on FOI that the Western Trust still hasn't implemented them. I am going, you are telling the public everything has changed, we are on top of things, really learning lessons, the glib phrases they trot out, and they haven't. This is my big worry with this whole process. Adult safeguarding procedures are there to be followed. It's not your option will I use them or will I not. But it seems to be in the Trust nobody seems to know them, understand them or rigorously apply them. 11:47 11:47 11:48 11:48

82 Q. Well you have been making these points forcefully now, you also were led to form AFM, Action for Muckamore in 2020? 11:48

A. 2019 or '20, yeah.

83 Q. You mention that briefly in your statement. Can you tell the Panel a little bit more about how that came about?

A. Basically once the scandal broke I sat back and watched. I was watching in the paper, a friend who is very close to the press says the feelers s are out trying to find out who this is that's at the centre of the scandal. I says look, I'm not interested in a public profile, I am going to sit it out and I'll just bat behind the scenes. So I was watching stories in the paper, staff feel they are going to be killed, blah blah blah, all these sort of stories. I commented on one RQIA report and I made comments, check that because RQIA say this and the staff say that. On the basis of that, Irish News said to me how do you know so much about that, I says I am the one who started this, she then came out and that's who we -- 11:49 11:49

84 Q. Was that the journalist? 11:49

A. The journalist, she was the health correspondent with the Irish News. I showed her, there is all my paperwork, that's what I am getting on paper. She ran the story. So we built up a good relationship. I told her, I says, I had no experience with dealing with the papers. I says I don't want any embellishment, any grand tall stories. I said if there is allegedly two incidents or 202, that's what you print. She says that's the way we are, we are reputable, there will be no story telling. So I built a good relationship with her and thankfully the whistle blower was keeping her abreast of things. And that's one thing I like in this whole sorry mess, that there is still at least one person with integrity. There is a cover up, you have 11:50 11:50

to expose this, they are totally resistant, you are not getting a public Inquiry, they are totally resistant to a public inquiry. The whistle blower is worth their weight in gold.

85 Q. Just come willing back to Action for Muckamore, where did the name come from? 11:51

A. Action for Muckamore came, we used to go up, there was another group that used to meet and do charitable work for various patients and so forth. And the scandal broke and we went to maybe three or four meetings, monthly apart but there was no, there seemed to be no appreciation of the magnitude of the scandal, of how wronged we felt as individuals. We kept getting told, you know, my relative is treated like a king in here, issues like that. One story that was in the Irish News the day of the meeting was made disparaging remarks to, I says look, see that story in the Irish News, I put it in and I have my file here and I can prove every line of that story is accurate because it is what the management gave to me. It ended up one of the girls in the group, I don't know if I am allowed to mention her, she would be another witness today, and she says right, that is it, we are going to form our own group. I had phone calls, we met in her premises because she does work with learning disability. Some of us got together saying we are going to form a group, Action for Muckamore, so we then became the sole voice looking for a public inquiry. 11:51 11:51 11:51 11:52

86 Q. How many of you were there at that stage?

A. At the start probably only about six or seven.

87 Q. How did that develop then and how many members have you got now?

A. There is about 35 ish. It is sort of, there's people that are members and they just say ah, you work away, do press releases, anything you do, we follow. It's been a very easy group to be the spokesman for. 11:52

88 Q. Do you have regular meetings?

A. Not regular in the sense, there is not one every month, it's meetings as required. I told the group look, if I start calling meetings with no real agenda, no reason, people get dissatisfied with that. I say any time there is something of interest or any time we need to meet as a group to make a decision we do so. We meet regular. 11:53 11:53

89 Q. I take it you wouldn't have formal minuted meetings or that kind of thing?

A. Sometimes we do. If it is an important issue I would minute the meetings. The beauty is the group flows like water. There is a problem, what way are we dealing with this, right, what's the decision? Every decision is unanimous, left or right or down the road. I have never had a cross word with one of the group, it just flows like water. We are all on the same page, which is a very easy job to manage. 11:53 11:53

90 Q. There are three more issues that I want to deal with in the open session, P96's Father, and first of all, I want to give you the opportunity in relation to the various ideas that you have suggested towards the end

of your statement and the various things that you would like the Inquiry to do. Now bearing in mind we are in open session, is there anything that you would like to add to that shopping list if I can call it that, at this stage? 11:54

A. In open session, an individual statutory duty of candor. This is the biggest adult safeguarding scandal in UK history and we are back to the same issues, Hyponatremia, all of the previous scandals, you need the statutory and individual duty of candor to force 11:54 people to be obliged by law to tell the truth. I think that's hugely important. We shouldn't have to have a public Inquiry, make the same recommendation, have the same type of failings, lack of governance, lack of oversight, cover ups and then go back to crying we need 11:54 an individual statutory duty of can dour. How many times do these things have to happen before politicians will enact what's needed?

91 Q. The next thing I wanted to ask you about was the staff at Muckamore who worked with your son. I note that at 11:55 paragraph 83 of your statement you say "there were some individuals who properly cared for P96 and I feel it is important to recognise this."

A. That's right.

92 Q. I think it is fair to say you also made that point in 11:55 your communications with the Trust?

A. Mhm-mhm.

93 Q. And I just want, do you want to say anything more to the Inquiry about your acknowledgment that there were

staff who did properly care for P96?

A. Yes. I think it is important, sometimes in a scandal the negative press takes preeminence and I have no doubt, in that letter, if you have seen it, I make it quite plain it would be a hard paper round coming into work every day, staff were working long hours to maintain safe staffing levels, et cetera. Some staff were providing very good care. Some of them moved from Muckamore to his facility to transition him, especially his favorites. I am very grateful for the ones that went the extra mile and especially one that I mention in a senior position. For instance once it was obvious I was on the war path and I was so prominent with Action for Muckamore, anything that happened, she would tell me. If I came up on a visit, I want to let you know there is an elderly visitor came in, opened the door and P96 charged out the door and got out, right, okay. I was happy enough as long as I was being informed and how far did he get? So she would tell me if anything adverse had happened, P96 has been assaulted by patient A, right, fair enough. So it was good to know when that individual was on and she was held in high regard by the management of the Trust because certain things never happened if she was on duty, which I thought, that would be appropriate, that would be my assessment of her too. So, yes, there was ones I named were very good with P96 and worthy of the accolade.

11:55 11:56 11:56 11:56 11:57

94 Q. P96's Father, finally in open session I just wanted to

ask you about something we touched on earlier and that's resettlement. P96 is now in the Praxis apartment that you referred to?

A. Yes.

95 Q. And has been since February 2020 I think. Now, you say in your statement that was achieved with relative ease, you think that was maybe more do with the hospital wanting rid of P96 as a thorn in their side? 11:57

A. We are very conscious that I was seen as the problem. I was the one always identifying problems with Muckamore, raising complaints, speaking to the press. The process to get him out was excruciatingly slow. 11:58

96 Q. That's what I wanted to ask you about?

A. It actually got to the stage that, without naming the person, the Praxis Operations Manager and her assistant came out to my house and says look, every month we go up, where is the date we set, have you got a comprehensive risk assessment, have you got a feeding assessment, no, you do that, you do this and it dragged on month after month after month. In the end they came out and says this is going to go forever. With your permission at the next meeting we are going to set a date, P96 is moving on that date, can you all get your ducks in a row, are you happy with that? I says I would be delighted with that. So that's what happened at the next meeting, we're setting a date, everybody gets all the props in position, get your risks assessment, get your feedings plans, everything you need, get it in line, that's the date he is moving and 11:58 11:58 11:58

that's how it happened.

97 Q. Do you feel that you were sufficiently involved in the process even though it did take a significant period of time?

A. Yes, I was shown plans of the house. I heard they were doing all their risk assessments. It is still another process, you were never told what was your entitlement for your loved one. Is he allowed here, is he allowed to live there, what type of accommodation. I still wouldn't know if you asked me what is the procedures and what is in the budget for an average person's discharge from Muckamore. I still don't know how that would work. 11:59 11:59

98 Q. What about P96's involvement, was he brought to the facility to check it out, did he meet staff before moving? 12:00

A. They had in reach, an in reach team came up to meet him. Now initially the Praxis Operations Manager said, you know, we have never put the amount of work getting to know a patient, we normally come up, do in reach, get to know them, get their feeding plans, risk assessments and discharge them. She says we have really exceeded that quite far. But once he actually moved they actually told me that that's going to be their template for moves. They says the extra work actually paid off dividends because the phrase I was told when P96 was moving from Muckamore to this new facility to new staff, you are going to have to ride the storm. Right, fair enough. And relatively, he 12:00 12:00

settled in very easily. As a matter of fact after two weeks a senior personnel from Muckamore who was down with him told me I can't keep my staff any longer, he's that good and it went that well, I couldn't justify to my bosses keeping us here any longer, it is going way, 12:01
way better than we dared hope which was good.

99 Q. How is he doing now?

A. He is doing brilliant up there, he is very, very good. In perspective he is there about three years, eight months. In that time hands on for about a minute four 12:01
times. And I compare that, maybe not -- it would be radically different in Muckamore.

100 Q. P96's Father, those are the only matters I want to raise with you in the open session. We are going to move into closed shortly. Before we do that, the Panel 12:01
may have some questions in open. P96's Father, can I give you just a final opportunity to say anything further that you might wish to in the open session?

CHAIRPERSON: Before you do, sorry, I did want to ask you something. Just about advocacy services and what 12:02
you were aware, and what was available, you talked about the PCC and your unhappiness with the service you got from them. Did you look to see if there were any other advocacy services?

A. Yes, before I met H77. 12:02

CHAIRPERSON: Yeah.

A. My wife was on holiday and I wanted an independent witness and I noticed a poster up in Muckamore and it was Bryson House.

CHAIRPERSON: Yes.

A. So I rang them up, look, I need somebody to come with me to a meeting regarding that issue and they sent me up, it's in my statement, I don't want to mention a name, I don't see her name there. 12:02

CHAIRPERSON: The names don't matter, it is really the quality of the service that you got and whether you thought they were helpful.

A. I arranged to meet her 20 minutes before my meeting with that individual in the Cosy Corner, the wee restaurant on site. I met her and she says listen, all I know is three bits of information, I can get nothing out of them. She told me look, H77 is so open and transparent, don't prejudge him. 12:03

CHAIRPERSON: That put you on your guard, I know you mention that in your statement. 12:03

A. I hate that phrase. Every time somebody does it they do the exact opposite. She says don't prejudge him, when you come out of the meeting you will be so happy you met him and all your questions will be answered, I have known him for years, brilliant. And I said to her look, I am going to meet, this is my words, I am going to meet a pathological liar who is going to hide behind data protection and an ongoing police investigation. No, no, no seriously, give him a chance. I says fair enough. I went to the meeting and -- 12:03

CHAIRPERSON: I just want to focus on the service that was provided, it didn't do --

A. She was there, to be fair to her, I wanted her there as

an independent witness to acknowledge everything that is said because the other side was taking copious notes.

CHAIRPERSON: Yes.

A. The safeguarding officer, where she wasn't. 12:04

CHAIRPERSON: Yeah, okay.

A. I would have liked somebody that --

CHAIRPERSON: Did you ever take it forward with Bryson House, did you get any other assistance from them or was that the one meeting that they attended? 12:04

A. That was the one meeting, my problem was --

CHAIRPERSON: Understand, okay.

A. I looked on her assessment of the individual was totally inaccurate, probably working too close with somebody, to be fair. You maybe have a different view 12:04 than somebody coming from --

CHAIRPERSON: Others you understand have had different experiences but your experience obviously wasn't a good one?

A. Yeah, but I appreciated her coming as my witness, my 12:04 independent witness.

CHAIRPERSON: Thank you. All right, I think we now move into restricted session. Can we go straight into that or do we need to rise for any reason?

MR. DORAN: Maybe just a couple of minutes. I am ready 12:05 to go, I just need a couple of minutes.

CHAIRPERSON: Absolutely, do you want us to rise or can we just wait.

MR. DORAN: Probably better to rise actually.

CHAIRPERSON: It always adds 10 minutes.
MR. DORAN: Let's not allow it to add ten minutes. Shall we say 10 past 12.
CHAIRPERSON: That's in two minutes, if we can do that you will get a reward of some sort, okay. 12:05
MR. DORAN: I think we've just uncovered a difference between the two clocks in the room.
CHAIRPERSON: Five minutes, okay. Five minutes, but can we really try to stick to five minutes please. Thank you very much indeed, okay. 12:05

THE HEARING ADJOURNED FOR A SHORT TIME.

THE HEARING RESUMED AS FOLLOWS:

12:09

RESTRICTED SESSION

LUNCH ADJOURNMENT

THE HEARING RESUMED AS FOLLOWS 13:26

IN OPEN SESSION

CHAIRPERSON: Thank you.
MR. DORAN: Good afternoon Chair and Panel members. 14:29
This afternoon, first we'll be hearing from P90's sister and after that, P90's brother. You will see that P116's mother is also scheduled to give evidence today. Unfortunately she has informed the Inquiry

through her representatives that she is unable to attend today but she is content to have her statement read to the Inquiry Panel.

CHAIRPERSON: I think actually that's the same witness that we had to push back from the 28th of September, so. 14:29

MR. DORAN: Yes indeed.

CHAIRPERSON: Obviously best wishes to her but I think we have got to get on with that one.

MR. DORAN: In relation to the first witness today I understand there is some correspondence before the Inquiry relating to possible restriction. I am not going to go into that in detail. I understand that you, Chair, have had an opportunity of considering that. 14:29 14:30

CHAIRPERSON: I mean without going into detail, because I think to do so would simply highlight the offending passages as it were, or the non-offending passages, there is a letter dated today from the PPS where they have invited me to consider a Restriction Order in relation to two paragraphs. I have considered the application very carefully, I think they have withdrawn one of those. 14:30

MR. DORAN: Yes, Chair.

CHAIRPERSON: I have considered the application very carefully, I have applied the low bar that I do apply in relation to the possibility of interfering with criminal proceedings, but even applying that low bar, I cannot see any public interest in restricting the 14:30

paragraph that has been referred to. And so I am not going to make a Restriction Order.

MR. DORAN: Thank you, Chair, I should say there was communication from PSNI in respect of the matters as well but the matter is now --

CHAIRPERSON: I have considered it very carefully and doing the best I can, as I say, applying a low bar I still cannot see any prejudice whatever, okay.

MR. DORAN: Thank you, Chair. The witness can now be called please. 14:31

CHAIRPERSON: So feed is open and we can call the witness.

MR. DORAN: And the witness is content to be known by her first name, Brigene.

CHAIRPERSON: And there is no sensitivity around the publication of that either? 14:31

MR. DORAN: No, Chair.

MR. DORAN: Her brother's name is Bryan.

CHAIRPERSON: Can I apologise to everybody that they have had a delay, having asked everyone to be here promptly, there was a delay, so apologies. 14:31

P90'S SISTER, HAVING BEEN SWORN, EXAMINED BY MR. DORAN AS FOLLOWS:

14:32

CHAIRPERSON: I gather we can use your first name?

A. Brigene.

CHAIRPERSON: Thank you. But we are not going to use your surname, all right. Brigene, you and I have met a

couple of times before.

A. Yes.

CHAIRPERSON: I just want to welcome you to the Inquiry. Thank you for making your statement. I'm sorry you have had a bit of delay this afternoon waiting in that little room but we are now ready to start. I am going to hand you over to Mr. Doran whom you have also met a number of times. 14:33

A. Thanks you.

101 Q. MR. DORAN: Brigene, thank you for attending to give evidence today. As you know I am counsel to the Inquiry and we've spoken this morning about your evidence and we've also met before on a few occasions in the context of the Inquiry. We are going to be talking today about your brother, Bryan, and specifically about his time as a patient at Muckamore. And in fact I think Bryan has been a patient at Muckamore since 1988; isn't that right? 14:33

A. That's right.

102 Q. You made a recent statement to the Inquiry solicitors, isn't that right? 14:33

A. Yes, I did.

103 Q. And that's dated the 2nd October 2023. Now, I understand, Brigene, that you would like to depart from our normal practice and read the statement in yourself? 14:34

A. Yes, I would.

104 Q. Which of course you are more than welcome to do. But I understand before that you have arranged for a video to be shown; is that right?

A. Yes, it is just a short video and it shows Bryan. With mummy, myself and my sister at the Gateway Club whenever he was at home as a child. I wanted it to be shown so that it would give the Panel perspective of the kind of life that Bryan had at home before he went to Muckamore.

105 Q. Yes, thank you, Brigene. We are going to arrange for that to be shown just very shortly and then we'll move on to the reading of your statement. I'll just say one thing before we proceed any further. You will know from the statement and from the Inquiry practice that rather than use the names in many cases we use cipher numbers and can I just ask you to adhere to that throughout -- 14:34

A. Yes. 14:35

106 Q. The reading and indeed throughout any questions that you may be asked afterwards?

A. Yes.

107 Q. It is very difficult?

A. Yes. 14:35

108 Q. If it doesn't work we have always got the mechanism to stop if need be. We are going to proceed now to show the video.

CHAIRPERSON: Will you identify which one Bryan is for us? 14:35

A. You will see he is a small child in mummy's arms, she is dancing around with him, and my sister.

CHAIRPERSON: Thank you very much.

[SHORT VIDEO PLAYED.]

A. That's the conga we're doing there.

CHAIRPERSON: Even I recognise that.

A. That's my sister with Bryan with Bryan coming round with the hair band on there. That's Bryan. 14:37

CHAIRPERSON: When was this party?

A. It's about approximately 50 years ago. That's mummy and Bryan just dancing round there now. That's them again. That's mummy. 14:37

CHAIRPERSON: Do we see Bryan again?

A. I'm not sure, it should be nearly finished, it's a very short video.

CHAIRPERSON: All right.

A. I think that's nearly the end. 14:40

CHAIRPERSON: Well thank you very much for that.

A. I just would like to say I'd like to hope that that gives the Panel and everyone just a flavour of the life that Bryan did have when he was at home and how not only he, but the rest of the learning disabled people in our community, were able to enjoy a social life at home and they were really integrated into our community at the time and we had so many young volunteers. 14:40

CHAIRPERSON: Can I ask where that was, where was that party? 14:40

A. Sorry.

CHAIRPERSON: Where was that.

A. Where was it?

CHAIRPERSON: Where did it take place.

A. It was in a local hall. Every fortnight we had an evening for them and then of course special occasions like Christmas and Halloween and stuff like that.

CHAIRPERSON: Well thank you very much, okay.

109 Q. MR. DORAN: Brigene, I am now going to ask you to read your statement. I am just going to flag up one thing in the first line were you say I, Brigene. Just use your first name, so it is I, Brigene, make the following statement and you can proceed from there? 14:41

A. Okay, thank you. 14:41

"I, Brigene, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. In exhibiting any document I will number my documents so that my first document will be Exhibit 1. I can 14:41 confirm that my any handwriting which appears on any of the exhibited documents is my own. Any redactions which appear on any Trust documents received by me were applied before I received the documents.

14:41

My connection with MAH is that I am a relative of a patient in MAH. My brother, Bryan, is currently in MAH and has been since 1988. I attach photographs of my brother at Exhibit 1.

14:42

I am also the secretary of the Society of Parents and Friends of Muckamore hospital and a trained nurse with over 40 years experience.

The relevant time period that I can speak about is 1988 to date. My brother, Bryan, was born on the 10th October 1966 and he is 56 years old. He is a vulnerable adult who has a severe learning disability. He has a diagnosis of bipolar disorder and autism. 14:42
Bryan lacks capacity and he is non-verbal.
Our mother was Bryan's primary carer when he was at home. She continued this role until she died in 2015. After our mother died, my brother, Aidan, and I took on the role of joint controller for Bryan. We are also 14:42
jointly recorded as Bryan's next of kin.

I am 10 years older than Bryan who is the youngest boy of eight siblings. Our mother raised my siblings and I on her own in Ballycastle and we are a very close 14:43
family.

I remember when Bryan was brought home from the hospital when he was born. When he was a newborn there was nothing to suggest that he had a disability. 14:43
However, Bryan did not then meet his developmental milestones as a young child. For example, he could not roll over or sit up. My mother brought Bryan to the doctor and was told that Bryan would never be any better than he was at that time. The doctor told my 14:43
mother that she should put Bryan in an institution and forget about him. I remember this clearly as when my mother came home she was so upset. My mother did not accept what the doctor had said and made the decision

that Bryan was to stay at home with his family. My mother always insisted that he would not be going anywhere and that he would be looked after at home.

Bryan's disability comes from oxygen deprivation during birth. It is my understanding that our mother's labour with Bryan was sustained and Bryan was deprived of oxygen. As far as I am aware, Bryan was not on any medication whilst he lived with our family and I understand that the doctor had said he was unable to prescribe any. 14:44 14:44

After our family found out about Bryan's disabilities our family life willingly and lovingly revolved around him. For example, we had a rota for watching Bryan and if we wanted to go out, we had to think about whether it was suitable for him. Our mother had taught us siblings that Bryan was a special child and that our family had been honoured to have a special child to look after. Our job was to look after Bryan, to be his supporter and protector. 14:44 14:45

When Bryan was about five or six years old our mother discovered a programme developed by the Peto Institute in Hungary. Peto's ethos was to help children with learning disabilities. Another lady in the town, who also had a son with a learning disability, found out about the Peto Institute programme. She took her son to a Peto Institute in Philadelphia, learned the 14:45

exercises, and when they returned she taught these exercises to other parents in a support group for parents with children with learning disabilities.

My mother and her friend drew up a rota together to do the programme with Bryan which involved intensive exercises for eight or nine hours per day. The program made a difference to Bryan as he could then kick his legs and sit up with pillows. Our mother was very resourceful and she was determined that Bryan would enjoy his life. Our mother also made a special swing to allow Bryan to sit up in the garden. Eventually, he stood up, then he started to walk, and eventually Bryan could run. 14:45 14:46

We lived in a seaside town and Bryan loved the beach. Bryan did not have a sense of danger so he would run into the sea and our mother could not swim. Our mother made a harness for Bryan so that he could enjoy the shallow water and would still be safe. 14:46

Bryan was happy living in our community. He had a good quality of life. He loved his swing, and he loved the water. He was also able to attend the local Gateway Club which my mother and I ran. Bryan really enjoyed going to the Gateway evenings. His whole environment was surrounded by his family who cared for and loved him. 14:47

Bryan would have been known to our neighbours. For example, a neighbour of ours always sent a Christmas present for the "wee boy". Our neighbours would know that if Bryan ran out to bring him back to us.
Bryan went to Sandleford School in Coleraine, a special 14:47
school for children, until the age of 18 and then to the Mountfern Adult Centre, Coleraine. Mountfern was a day centre for adults with limited capacity. Mountfern did activities such as carpentry and gardening. Bryan lived at home with our family in Ballycastle until he 14:47
was 21 years old.

Bryan was at ease at home but he did have some self-injurious behaviour before he went to MAH such as banging his head, scratching or nipping himself. At 14:48
times Bryan would also pull the hair of his siblings but these occasions would have been rare. I do not remember Bryan injuring anyone in the community and he was always supervised.
14:48

When Bryan was about 18 or 19 years old his behaviour became increasingly challenging and aggressive. Bryan's outbursts were increasingly frequent and intense. In between outbursts Bryan was happy but his outbursts were difficult to manage. Bryan started 14:48
having more episodes where he would bite or head-butt myself and our siblings.

Bryan had an outburst in February 1988 whereby he

attacked our mother. Our mother was becoming frailer at this stage and Bryan was a big, hefty man. Bryan had pulled our mother to the floor and was pulling her hair. Our brothers had to intervene to protect her. Following this incident our mother was advised to take Bryan to the doctor who suggested that Bryan should go to MAH for assessment and consideration of medication. I had never heard of MAH before this. 14:49

Bryan was admitted to MAH to ward M7 on the 22nd February 1988 and detained under the Mental Health Northern Ireland Order. I remember that the GP had to get a social worker to sign a form. Our family was told that Bryan would be a detained patient for an initial period and that he would be there for 12 weeks, during which time our family would not be able to visit him. We were told that the purpose of his admission was for assessment. I do not recall exactly when our family was able to visit Bryan but it was a much longer period than 12 weeks before we were able to see Bryan. 14:49 14:50

Bryan's records from MAH state that Bryan was admitted in April 1989. We do not have any records from any earlier date but this is incorrect. I remember the date Bryan was admitted as it was my friend's birthday and it is a day that I will never forget. Bryan's admission to MAH was the first time that he had been away from home. He had not even gone anywhere for respite as our mother always looked after him with 14:50

support from family.

I was with Bryan and my mother in the ambulance. We were all upset, and Bryan fought with the paramedics the whole way to MAH. It was a very traumatic day and the date is imprinted in my mind. The significance for our family is the apparent lack of any documentation relating to Bryan's detention prior to when he became a voluntary patient. 14:51

I recall that when we arrived at MAH we climbed out of the ambulance, and when we accompanied the ambulance men and Bryan to the ward door, a nurse opened the door. The ambulance men took Bryan in through the door and mammy and I made to follow. The nurse blocked our path and told us we were not permitted on the ward. He also said we would not be allowed to visit Bryan for 12 weeks as it would upset him. The nurse then promptly closed the door in our faces and we were left waiting outside. Mummy was distraught and I had to try and calm her down. We had to wait until the ambulance men came out as they were taking us home again. I recall thinking back to the time when mummy had returned from the appointment where the doctor had told her to put him into an institution and forget about him. I am sure the same thought was going through mummy's head because it was her worst nightmare. 14:51 14:52 14:52

During Bryan's time in MAH he has had quite a few

different consultants. One who stands out in my mind is Dr. H30. During the time Dr. H30 cared for Bryan I was able to form a good relationship with her, and we often had informal chats about both our lives. I recall one day while visiting Bryan, Dr. H30 came in while I was in the visiting room. I don't recall the specific date but it was in Erne Ward and before 2017 when the abuse was discovered. I think it would have been around 2016. Dr. H30 started talking but seemed upset. I asked her what the matter was and she told me she was leaving MAH. I was shocked as I had not expected this, and probably selfishly started to think of the future uncertainty of who would come to take her place. I had always been very pleased with Dr. H30 as she seemed to be a very good doctor who was conscientious and cared for her patients. I asked her why and she told me that she could not take it anymore. Dr. H30 then left MAH and took up a post elsewhere. At the time I thought she was maybe having a bad time as I was aware that she had problems at work before this. With hindsight I now feel that Dr. H30 had become aware of the ill-treatment and neglect which was happening to the patients. I have only spoken to her once since she left MAH. I asked her how she was getting on and she told me she was doing much better as she was now working in a place where they cared what happened to the patients.

14:52 14:53 14:53 14:53 14:54

Our mother was determined that whilst Bryan was in MAH

he would continue to know that he had a family and experience our love. I remember that she was concerned that because Bryan had a short memory span, he might forget his family. Her greatest concern was that, as Bryan did not have speech, he could not tell if something was wrong. My mother had been concerned about this as Bryan was growing up but this was heightened upon his admission to MAH. 14:54

We had a family rota to visit Bryan in MAH so he would see a member of his family every day. Some of our family went to see him every evening. This was approximately a 100 mile round trip from Ballycastle. We always thought Bryan would be coming home. We did not imagine that he would be moved to a Trust placement. My mother would not have let him go to MAH if she knew he would not be coming home again. My mother found leaving Bryan at MAH traumatic. She could not cope with him not coming back to the family home. 14:55

When we went to visit Bryan each evening he was in a locked ward. A member of staff had to let us in. Bryan was then brought out of the ward into a small room for the visit. The room was only about 5 by 10 feet. We were not allowed to bring him out for a walk in the grounds. Other than talking to him and playing games with our hands, there was not much we could do. I had to sit beside the door during visits in case Bryan lashed out. Visits could last a few minutes or 14:55

longer, for example, half an hour, depending on how Bryan was. It was upsetting because of the journey it would take to see Bryan and then sometimes the visits only lasted a few minutes. We were not able to speak with Bryan on the phone as this was beyond his abilities. If you give Bryan a telephone he might put it in his mouth or drop it on the floor. 14:56

When Bryan went to MAH he became a different person. It seemed to magnify the challenging behaviours that he had at home, including banging his head continuously off a wall, nipping himself or hitting his face and/or head when becoming agitated or anxious. The hospital environment could be loud, and this would overwhelm him and trigger his behaviours. 14:56 14:57

At the beginning of his time in MAH Bryan was moved around various wards. This is a recurring theme that has continued throughout all the years he has been in MAH. After M7 he was moved to C9, Cushendun. He was also on Moylena Ward until 2016 and from there he was moved to Erne Ward and then to Killead ward in July 2021 where he currently resides. 14:57

The practice of continuously moving Bryan to different wards has been very difficult. As Bryan has autism, change is very difficult for him. He becomes stressed because he has had to frequently adapt to an unfamiliar environment. 14:57

In or about January 2021 the staff wanted to move Bryan from one side of Erne Ward to another because a patient with whom he shared that side of the ward was assaulting him. Bryan was reacting to these assaults with self-injurious behaviour, for example by banging his head off the wall or nipping himself. Sometimes he would pull staff member's hair. 14:58

These incidents of assaults on Bryan by the other patient had been ongoing since the 10th March 2014 and November 2016 as detailed in my handwritten notebook entries at exhibit 2. I have also included my own typed version of these notebook entries. I recall that by the 6th November 2014, a further 11 incidents were reported to me by staff where Bryan had been slapped, kicked, bitten, nipped or hit by this other patient. I spoke to Dr. H30 about Bryan being repeatedly assaulted and I was assured that there was a plan to separate Bryan from the patient who was mainly involved in the assaults. However, there was no sign of any effective plan and in 2015 I was informed by staff of a further 15 assaults on Bryan by this patient. 14:58 14:58 14:59

Although Bryan was moved from Moylena ward to Erne Ward on the 18th February 2016, the patient that had been assaulting Bryan was moved with him. The staff seemed to do little to protect Bryan. There is CCTV footage of an incident on the 21st January 2020 showing two 14:59

members of staff supposedly providing one to one observation of Bryan, using their phones and ignoring repeated assaults on Bryan by the other patient who succeeded in pulling off Bryan's top and throwing it out of the window. It was retrieved by one of the staff who used it as a game with the other member of staff, throwing it back and forth which escalated the other patient's behaviour. 15:00

Despite all that, Bryan and the patient who repeatedly assaulted him remained together until January 2021 when we were informed that Bryan was to be moved. We expressed extreme concern about the plan to move Bryan because it would have a very detrimental effect on his mental health. I asked for the other patient to be moved as he was the one causing the problem but was told by Dr. H223 that the other patient could not be moved. 15:00 15:00

As we were told that the other patient could not be moved, we agreed that Bryan would go to another part of Erne during the day when he was doing activities and would return to his part of the ward after activities. The reason for this was so that Bryan's environment would not change and that he would continue to have some company as he struggles with isolation. We were then told by telephone that Bryan had been moved to another area of Erne. 15:01 15:01

When we went to visit Bryan in Erne Ward we saw that his bed had been moved. The room he had been moved to was at the very end of a long corridor. Bryan was very isolated in this room. The only company he shared was with the one member of staff who looked after him. Our family complained about this and registered our frustration that the agreement had not been followed. We did not consider such an isolating move good for Bryan. Bryan remained in this part of Erne Ward for seven or eight months until his move to Killead Ward in July 2021. 15:01 15:02

Only in recent years, and on request, was our family allowed to access Bryan's bedroom. Previously, before Bryan was moved to Erne Ward in 2017, his bedroom was a dormitory. On one occasion in 2015 when work was being done in Moylena to divide the dormitory into individual rooms, I was brought to the dormitory. It felt like an 18th Century institution. Erne Ward was very dilapidated and so far as I was concerned not fit for human habitation, and yet Bryan stayed there for about eight months until he was moved to Killead Ward. It concerned me that we had not been shown Bryan's home. 15:02 15:02

Bryan has a sensory issue where he swallows food and then regurgitates it. He did this before MAH when he was at home. Our family managed it by being very attentive when he was eating to stop it being a problem. The occupational therapists have assessed 15:03

Bryan as at risk of choking. He has one to one monitoring 24/7 unless he is out of the ward and then it is two to one. The level of observations is not only informed by the choking risk, but also due to safety risk given Bryan's lack of capacity. 15:03

I recall visiting Bryan in Erne Ward and finding a female member of staff feeding him a yogurt and a banana. I found this upsetting and inappropriate as she was feeding him. Bryan can feed himself independently with supervision and this felt like an 15:04 erosion of his independence. He was sitting at a dining room table and there was no plate to put the food on. I spoke to the staff member and told her she should be encouraging Bryan to feed himself. She then peeled the banana and used the spoon to cut slices off 15:04 and scrape them onto the bare table for Bryan to pick up and eat. I felt this was so degrading and unhygienic that I reported the matter to the ward manager, H519, who said she would deal with it.

15:04

In the past few years Bryan's weight has increased. We became aware through general conversations that Coca-Cola and chocolate were being purchased with Bryan's money. We felt that this was strange as Bryan had never eaten chocolate nor drank Coca-Cola prior to 15:05 this. Bryan had always preferred crisps to snack on and either water, milk or diluting juice to drink. We have mentioned a few times about Bryan's weight increase but we did not make an issue of this as we

were scared that Bryan's snacks would have been stopped and this would have had a detrimental effect on his mental health.

We never had any proof of whether the snacks were for Bryan or for someone else. We also felt that Bryan's weight increase is due to a lack of exercise as when we visit we invariably find Bryan reclining asleep in a Chair. Bryan appears to be allowed to sleep for long periods during the day. We have raised this many times as, apart from his weight problem, Bryan is not a good sleeper at night, so we felt that sleeping during the day would only exacerbate this. We have on several occasions, had to ask for Bryan to be given walks in the grounds, or to walk in good weather to Moyola Day Care instead of being taken on the bus which is approximately 100 metres. We felt all these things would help to de-escalate aggression, decrease boredom and help Bryan to form a more regular night-time sleep pattern. 15:05 15:05 15:06 15:06

In Bryan's care plan it is recommended that he has two sessions of swimming per week, regular walks in the grounds, visits to home on the bus and five day centre visits per week. It is also recommended to have one session of baking per week. During lockdown when the day centre visits were not possible staff were to do daily activities with Bryan on the ward. This is also meant to happen at the weekend or bank holidays. When 15:06

the day centre is not available, staff on the ward are supposed to initiate activities with Bryan within the ward setting.

These activities are not happening. We have been told that this is because of a staffing crisis. I received a letter on the staffing crisis dated 18th March 2021 which I attach at exhibit three. Even so, I do not understand why, as Bryan is to have one to one supervision 24 hours a day, the staff member supervising Bryan cannot initiate some activities whilst supervising him. 15:07 15:07

At times I have also had concerns about Bryan's appearance. When Bryan was in Erne Ward, I noticed that he did not have underwear on underneath his trousers. I queried this with the ward manager, H519, and was told that she would check with the staff and make sure this did not happen again. 15:07

Bryan was also dressed inappropriately at times. During a heatwave in June or July 2021, our brother Aidan went up to see Bryan. Aidan noticed that despite the windows being closed and the ward being sweltering, Bryan had been dressed wearing a sweat top. Bryan was stuck in the isolated area allocated to him without adequate ventilation or air conditioning. The anti ligature windows could not be opened and Bryan was not allowed outside to the adjoining garden area that would 15:08 15:08

have been cooler. We asked for Bryan to be allowed to access the outside area but were told this was not possible because the area was overgrown and had rubbish in it. Bryan was left inside in his hot room during the heatwave without a fan or a fridge to keep cold drinks in or air conditioning. When I visited him during this time Bryan was clearly very uncomfortable and was visibly sweating. Aidan and I made repeated requests for things to change and for Bryan to be allowed a fan, a fridge and access to the outdoors. It took at least a week for accommodations to be made. 15:09 15:09

There were times when visiting that we had to wait for Bryan to be brought out of the visiting room. The reason given was mainly that Bryan had messed his clothes and needed changed. We accepted this as Bryan is a messy eater but were unaware of what state his clothes were in or what had caused them to be dirty. I also recall a time when Bryan was in Erne Ward, it would have been between 2016 to 2021 when I visited. Bryan was sitting on the couch in the common area and arose to walk across the room. He had jogging bottoms on which were loose and upon rising his trousers fell revealing that he did not have any underwear on. I spoke to the ward manager, H519, about this. She seemed unperturbed like this was not out of the ordinary and said she would speak to the staff. I never heard anything more about it. 15:09 15:10 15:10

Sometimes Bryan's clothes were torn and on occasion he would be wearing someone else's clothes. Our family have always provided Bryan's clothes so I don't understand how that could happen.

15:10

MAH did Bryan's laundry. Bryan is and always has been completely dependent upon carers for toileting and personal hygiene. I always hoped that this was being done correctly, but sometimes during visits I noticed faeces around Bryan's fingernails, and tips of his 15:11 fingers. I have had to ask staff to wash Bryan's hands and cut his toenails.

Following the lockdown March 2020 we were not allowed to visit Bryan at all for over a year. Despite this no 15:11 or insufficient efforts were made by management to accommodate family visits in person. Visits are still very restricted. I would telephone for an update from ward staff but it was very difficult to get anyone to answer the telephone. This was particularly difficult 15:11 for me as Bryan cannot speak on the telephone himself to keep in touch with us. We bought Bryan a tablet last year to try and help with this.

We had to advocate hard with the management of MAH to 15:12 install updated technology at MAH which would enable us to have Zoom visits with Bryan. Zoom has not been successful as there is bad internet signal at MAH, some staff are not able to work devices, some devices are

not charged and at times staff forget to make time for a Zoom call. The Zoom facility does nothing to assist Bryan. He can hear our voices but he does not understand that we are not present with him.

15:12

During the Covid 19 pandemic we were not allowed to take Bryan out for walks around the grounds. Before the pandemic Bryan was allowed to come home for a couple of hours at the weekend, however this was stopped and not restarted because there were never enough staff to help to take him out of the ward.

15:12

Since about 2016, when Bryan went to Erne Ward, there has been a lack of privacy during family visits. Staff continue to sit in the room during the visit, meaning we get no family time. It feels like you are visiting an inmate in a prison. This has continued in Killead Ward. On previous wards we were permitted to visit Bryan alone in the ward visiting room and staff were nearby and could be called. I feel that the staff have forgotten that our family has looked after Bryan all our lives.

15:13

15:13

On the 9th October 2021, as part of the usual family celebrations for Bryan's birthday at MAH, we organised a party for him celebrate his 55th birthday. Due to Covid 19 restrictions, special arrangements were required and agreed with Bryan's named nurse H520 and H521, another member of staff. The agreement was that

15:13

one family member was permitted to be with Bryan bringing the cake and presents and the rest would participate from home via Zoom. H520 and H521 decorated the room. When our brother, Aidan, arrived at the agreed time he was denied entry by agency staff. 15:14
The cake and presents were taken from him. He was not allowed to celebrate Bryan's birthday with him and the Zoom with the rest of the family did not take place. I made complaints and requested information from H330, the ward manager, H230, the assistant service manager, 15:15
H300, the service manager and H522, the director for learning disability for the Belfast Trust. By the time H522 eventually responded a year had passed and she indicated that as the incident had happened a year ago and most of the staff had gone, she could not get any 15:15
information about it. She said, "we are very sorry that this happened." This was the first time in Bryan's life that his birthday had not been celebrated. This was very upsetting to the family. I had spent two weeks planning Bryan's birthday, including providing 15:15
decorations to the nurses on his ward for his room.

Communication at MAH has never been good but I feel it has deteriorated a lot in the last number of years. This has been exacerbated by things like a poor 15:16
internet signal, computers with no cameras, failure to be able to get anyone to answer the ward telephones, failure of staff to provide appropriate updates and a culture of divide and conquer where relatives are

actively discouraged from communicating with other families. We have felt for a long time that families are not always being told the truth. Our feeling is that if something works in the Trust's favour you will be told, but if it is something which would not be good for the Trust, or might get someone into hot water, then you will either be given an alternative version or you're not informed at all. I am aware from my work with SPFM that other families have had similar experiences. 15:16 15:17

In attempts to improve communication for families, and after much discussion, I along with the then Interim Director For Learning Disabilities at Belfast Trust, H287, set up a carers forum. The purpose of this group was to afford relatives a forum whereby they could come together, raise issues or concerns, and learn from other relatives's experience. The forum was to be attended by a minimum number of Trust officials to allow relatives to speak openly and if on occasions it was felt to be required, other professionals would be invited to attend a meeting. 15:17 15:17

Issues raised would then be taken back to the relevant people in the Trust and resolutions sought. As time passed and management changed, more and more managers began to attend and relatives found that when they raised an issue they were told 'this is not the right place' or 'we will discuss this outside the meeting'. 15:17

Subsequently people felt they were being put down, and the manager would not come back to discuss the issue with them so it never got resolved. Relatives became despondent, and gradually actually stopped coming. I am generally the only relative who consistently remains attending these meetings. I have often told myself I was going to stop attending these meetings but I keep going as I would not want another relative to turn up and feel overwhelmed or unsupported. I do feel that MAH management have destroyed what was initially a good communication tool, and a support network for families facing many challenges. MAH management were supposed to be working on their own communications strategy, but very little has come of this. 15:18 15:18

It is only in the last few years that our family have been able to become involved in Bryan's care. We had to advocate to be included in multidisciplinary team meetings (MDTMs). Dr. H223, who is Bryan's present consultant, has included us. In the last few months however, these meetings have not been happening. The in person meetings were downgraded to a weekly telephone call and in the last couple of weeks they have not happened. 15:19 15:19

At different times over the years our family has heard and seen things which have caused us concern. We noticed unexplained marks and bruises on Bryan's body, and we noticed that Bryan was less happy in MAH than at

home. Bryan was not capable of telling anyone about the bruises or marks on his body. From in and around 2014 our family became worried about the frequency with which these marks were appearing. I started to keep systematic notes to have an accurate record. I would tell our mother about these marks. Our mother was not trusting of the staff at MAH. She did not Trust anyone who was not a member of our family with him. This was because Bryan was non-verbal and unable to really communicate anything untoward happening to him. Our mother would tell us not to make an issue of the marks and bruises because Bryan lived there and she was concerned that there might be repercussions for him. On the occasions when we did raise the issue of marks and bruises the staff would tell us that Bryan caused them to himself through self-injurious behaviour. 15:20 15:20 15:20

In December 2020 Dr. H223 said that he thought Bryan was having a delayed reaction to the abuse he had suffered, which our family believed to be largely perpetrated by one patient. I refer particularly to examples of incidents between Bryan and other patients between 10th March 2014 and 21st November 2016 attached as above at Exhibit 2 which are entries of specific incidents from my notebook. 15:21 15:21

In my notebook entries I have outlined that on 9th May 2017 I was informed by H525, the nurse in charge of the shift, about an incident on 7th May 2017 when a member

of staff pulled down Bryan's trousers and underwear, exposing him in front of other patients and staff.

On 21st January 2020 following the viewing of CCTV, an incident was reported in which two members of staff who were supposed to be providing one to one observation of Bryan and another patient were observed sitting in a corner using their phones, and ignoring repeated assaults on Bryan by the other patient who succeeded in pulling off Bryan's top and throwing it out the window. It was retrieved by one of the staff who used it as a game throwing it between them with the other member of staff which escalated the other patient's behaviour. The Belfast Trust reported the incident to the PSNI with the other patient as the primary victim and Bryan as the secondary victim. It required the DAPO to alert the CCTV viewers that concern was shown for Bryan. I re-referred this incident to the PSNI with Bryan as the primary victim. The PSNI referred it back to the Belfast Trust as a single agency investigation. I understand that both staff members, who were from an agency, were dismissed.

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On the 25th September 2020 I was informed that extensive bruising had been observed on Bryan's body chart by the night services manager. This was to have been followed up but it was never mentioned again.

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On 28th October 2020, H519, the ward manager, stated that Bryan had sustained extensive abrasions to his arm

and bruising after returning from the day care. I was told that no one knew how this had happened. I reported this to safeguarding on the following Monday. Following the report to safeguarding I was told by them that H519 had noted on PARIS two days after the incident, that she had observed him outside the window rubbing his arm against a tree. I do not understand why I was not told this at the time and I have concerns that the record has been fabricated. On the follow up interview staff accompanying Bryan at the time said they denied all knowledge because they were scared they would be blamed. 15:24 15:24

In the evening of the 29th November 2020 I was contacted by an agency nurse called H526 on Erne Ward. Bryan had been very distressed and displaying a lot of challenging behaviour since the previous afternoon. He was banging his head and hands causing himself injury. Analgesia given with no effect. PRN medication was given with no effect. The doctor had to be called to prescribe extra medication. I was told that the case would be discussed at the psychology informed partnership approach or PIPA meeting on Monday morning. I then requested that the doctor should contact me following the PIPA meeting to update us on what was discussed and what the medical team were thinking in terms of resolving it. The follow up did not happen. I then contacted H519, nurse manager, and H230 assistant services manager, requesting that the doctor 15:24 15:25 15:25

contact me. Eventually on the Thursday evening, four days after the PIPA meeting, Dr. H527 telephoned me to update me. Dr. H527 informed me that he had not been made aware that he was to contact me.

15:26

It was only following the shock of the publicity surrounding the investigations into abuse at MAH that our family became concerned about the possibility of Bryan having been abused by staff.

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I attach at Exhibit 4 details of an incident from 7th May 2017 that I was informed about on the 9th May 2017 by H525, the nurse in charge of the shift. H525 told me that a member of staff had pulled Bryan to his feet in the Erne Ward day room, and pulled down his trousers and underwear to examine a wound at the back of his thigh without seeking to protect his dignity. This incident was reported to the PSNI who, I was told, considered it an incident of bad practice to be addressed by training which was agreed with the Belfast Trust. I understand that the staff member was not referred to Northern Ireland Social Care Council or to the Nursing and Midwifery Council as healthcare workers do not require to be registered. I am told that the staff member did not return to work and handed in his notice. I regard this as completely unsatisfactory as there is no evidence that he will be required to undergo or has undergone training and I am concerned that this staff member is likely working with

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vulnerable people to this day.

I also attach at exhibit five the adult protection report dated 20th April 2021 in relation to the incident. I attach at Exhibit 6 minutes of an adult safeguarding meeting which took place on the 9th February 2021 in relation to my complaints about the incident on 7th May 2017 and other incidents. 15:27

I attach at Exhibit 7 the adult protection report on the investigation in respect of Bryan dated 15th July 2021 that was revised on 19th October 2021. It deals with an anonymous complaint to RQIA by a whistle blower on the 19th January 2021 outlining three adult safeguarding concerns about Bryan. 15:28 15:28

I refer to examples of incidents from 21st January 2020 to the 31st March 2022 involving staff members and other unexplained injuries typed from my notebooks at Exhibit 8. I do not have my original notebook entries to hand however, I confirm the exhibit is my typed notes of these notebook entries. 15:29

On the 2nd December 2020 I received a call from H283, safeguarding officer, to say there had been an incident whereby Bryan was accidentally locked in a room for a period on his own. Bryan's observation level is continuous one to one observation and during the period when Bryan was in accidental seclusion, he injured his 15:29

head by banging it against the wall. I asked for this incident to be included as part of the adult safeguarding investigation and I understand that the staff member involved was dismissed by the Belfast Trust. I was also told that on another occasion Bryan had been allowed to walk naked in the ward common area in front of other patients. 15:29

on the 9th December 2020 I received an e-mail from H519, ward manager, stating that Bryan had banged his head in the bus. There had also been two medication errors, including where Bryan was erroneously given another patient's medication. There is also an ongoing serious adverse incident investigation concerning this event. I have tried my best to get more information about this and have tried to get it escalated but I have received no information other than they have no record of the incident. 15:30 15:30

In early December 2020 I was informed that Bryan had been given a total dosage of Paracetamol which exceeded the recommended 24 hour maximum. I asked that this be escalated to adult safeguarding. On 27th February 2021 when Bryan was in the bathroom with a staff member who was attending to his personal hygiene, Bryan was somehow allowed to leave the bathroom by himself, walk the entire length of the corridor to the office and the front door. He was not stopped by a member of staff until he reached the front door. There has been no 15:30 15:31

explanation of how this was possible given that he was on one to one observation.

On 25th February 2022, Bryan was left alone in a sensory room for two hours. In that time he managed to take the cord from his joggers and tied it around his arm to the point where he caused bruises and bleeding. There was also a period when he was down on the floor and banging his head repeatedly. I was not told about this until 28th February 2022 at approximately 1:45 pm when I received a telephone call from H330, the manager at Killead Ward, informing me that Bryan had extensive bruising to his left upper arm from his shoulder to his elbow. Staff were questioned but apparently no one admitted any knowledge of how this happened. I saw these injuries for myself when I visited Bryan. There was extensive bruising from his shoulder to his elbow on his left arm with two areas of what had been active bleeding. Furthermore, Bryan can be seen on the CCTV with the cord wrapped around his left arm and rubbing vigorously for a period of 30 minutes. I was subsequently informed on 2nd March 2022 the incident had been referred to ASG and a DAPO, H239 was dealing with the case as investigating officer. Then on 10th March 2022 I received a further update after the DAPO had viewed the CCTV footage. From the CCTV it appeared that staff were in a different room talking, they were unable to observe Bryan from where they were and consequently Bryan was left unsupervised for about two

15:31 15:32 15:32 15:32 15:33

hours, with staff only entering the room on a couple of occasions for about a minute. In the light of this update I asked that this incident be escalated to an SAI. It was referred to the PSNI. I understand this incident has been escalated to an SAI however, to the best of my knowledge, the staff involved have not been suspended and I understand the file is currently with the PPS for a direction on charges. 15:33

On the 19th march 2022, unfamiliar agency staff were brought to supervise Bryan while his supervising staff took their 30 minute break. He was then left alone with an in reach worker who was only there to learn, with no access to an alarm if required. Bryan is quite capable of seriously harming himself in such circumstances which is why there are such careful risk management arrangements for his care. The incident is ongoing and forms part of the adult safeguarding investigation, although our family has heard nothing about it since. 15:34 15:34

On 28th March 2022, I was informed that Bryan had sustained bruising to his hand, which is believed to have happened two days earlier on 26th March 2022. I was told he had repeatedly banged his hand off a windowsill but when I inquired further, staff were not sure how this happened. The next day I received a call to inform me that there was a concern his hand could be fractured so the plan was to send him to Antrim Area 15:35

Hospital for an x-ray. The x-ray did not reveal a fracture. There was an investigation into this incident by ASG and a DAPO called H239 was appointed. I was told on 14th September 2022 that no further specific action would be taken in relation to this 15:35
incident but that the Belfast Trust would consider further training for staff members.

At the end of March 2022 I was informed by H330, nurse in charge of Killead Ward that the social worker, H84, 15:36
had noticed a bruise on Bryan's knee. I asked for this to be referred ASG because it seemed any time that Bryan had marks or bruises that nobody knew anything about how he sustained them. This incident was also one about which no further specific action would be 15:36
taken but that the Belfast Trust would consider further training for staff members.

on 28th June 2022, Bryan sustained an abrasion to the bridge of his nose and bruising under his left eye. 15:36
The staff did not inform our family of this. It was Dr. H223 who had visited the ward who told us. The staff said they did not know what happened. Dr. H223 said the staff told him there was a minor head banging incident the day before, which had resulted in only a 15:37
slight redness of Bryan's forehead, and which did not require any treatment. Dr. H223 was concerned that the explanation did not match the injury. The staff at MAH denied knowledge of how this occurred. This was

referred to the PSNI and an SAI was opened to investigate the matter.

In July 2022, Bryan sustained a further extensive unexplained facial injury, including an abrasion to the bridge of his nose. This was referred to the PSNI by safeguarding. I asked that an SAI be opened but I am unsure if this happened. 15:37

On 3rd August 2022, Bryan sustained an abrasion to his nose which the staff were unable or unwilling to explain how it occurred, but accepted that it happened between Bryan going to bed and rising in the morning. 15:37

More recently, some time between the evening of 31st January 2023 and the morning of 1st February 2023, Bryan sustained an injury that remains unexplained by MAH. This occurred notwithstanding MAH directing at a meeting on 24th January 2023 that staff were to sit inside Bryan's bedroom overnight to keep him under constant observation. The DAPO investigating this incident reports that documentation, including body maps for this period, have proved impossible to access. 15:38 15:38

The details of these incidents involving Bryan give an indication of just how often he is hurt, how frequently it is an unexplained injury and how difficult it is to get anything tangible done to improve the situation. Quite frankly it is difficult to have any trust and 15:38

confidence that Bryan will be safe whilst in MAH, but we have no option but for him to stay there until he could be resettled.

I refer to a safeguarding action plan dated 25th February 2021 at Exhibit 9 and updated safeguarding action plan dated 11th March 2021 which I attach at Exhibit 10, which covers some of the incidents in that period of incidents. 15:39

It has been particularly distressing for our family to know that Bryan has been a victim of abuse at any age. Our distress has been even more heightened because Bryan has had to remain in MAH despite being a victim of abuse there. It is particularly concerning as Bryan cannot communicate any distress or anxiety that he may be feeling at remaining in an institution and in an environment where he was repeatedly subjected to abuse. Bryan is non-verbal and he does not have capacity so it is impossible for him to inform us of any abuse. 15:40

Our family are very concerned that there continues to be ongoing issues surrounding the care Bryan is receiving, particularly in relation to his supervision level. 15:40

Bryan finds it difficult to adapt to new staff members who need to be introduced gradually. Changes of staff has always been an issue at MAH, but this has become

more prevalent in recent times. Recently, there has been a lot of agency staff who are mental health nurses as opposed to learning disability nurses who do not have the correct training to interact with Bryan and to deescalate behaviour. 15:41

The ward manager and deputy ward manager have also left Killead. An assistant services manager has been brought in since 8th August 2022 to take charge of the ward in the absence of a manager. I am concerned about the implications for Bryan's care and wellbeing over 15:41 the shortage of staff and the reliance on agency staff who do not know him.

On Tuesday the 13th September 2022, I received a telephone call from H528, the newly appointed assistant 15:41 service manager for Killead. H528 rang to report that the previous day there had been an adult safeguarding incident with Bryan. The nurse in charge of the shift had reported that an agency staff member allocated to Bryan had been found sleeping in the evening. The 15:42 staff member denies this but the nurse in charge is adamant. I asked for it to be escalated to ASG.

Later that day I received a call from H544 in ASG to say that they had received a referral. She told me that she had viewed the CCTV around the time this had 15:42 happened. The camera that she was able to view was not in the room where Bryan was, but was in the corridor outside. Bryan was lying in the chair in the quiet room. She said that she could only see from a

restricted angle. It seemed from her observation that the staff member was interacting with Bryan until a certain point and then he stopped interacting. She was not able to determine whether the staff member in question had been asleep or not. This is concerning in light of a recent incident in June 2022 when Bryan sustained significant injury when he was not properly supervised. 15:43

I also have concerns about Bryan being overmedicated. Before our family were involved in MDTMs we were told staff had to give Bryan his PRN. It is my opinion that PRN was being used as a first response as opposed to the nurses using positive behaviour support. In Bryan's care plan it provided that positive behaviour support should be used before PRN. I had become vocal about the overuse of medication because Bryan had been very sleepy during the day. Staff had been using medication every time Bryan became agitated. 15:43 15:43

I was advised on the 8th August 2022 by a member of staff during a telephone conversation that lazy staff on the ward were using PRN medications as a first line management of Bryan's agitation outbursts contrary to Bryan's care plan. This simply reinforced the concerns our family already had due to the number of times that we would go to visit Bryan to find him lying sleeping on a couch. This was the first real evidence we had received. This issue has been escalated to ASG. Our 15:44 15:44

family wondered at the time whether Bryan's apparent sleepiness was a result of his medication sedating him, together with a degree of boredom. As far as we could see the staff mainly sat in a corner observing Bryan, rarely interacting or doing anything stimulating with him.

Before our mother passed away in 2015 she looked after Bryan's money. The way it worked was that there was a float on the ward and Bryan got a personal allowance. His main account was controlled by the Belfast Trust. If he needed anything then MAH would tell our family who would provide it. A float of £100 was kept in Bryan's drawer on the ward for treats. Our mother would also send up extra money, usually around £300 every couple of months, just in case Bryan would need money for anything. Bryan also received £15 per week for going to day care. This would always be deposited into the finance office on site at MAH. The finance officer was H351.

When our family deposited money in MAH for Bryan's use we always ensured that we were given a receipt. However, we were never provided with receipts for the goods which the money was spent on. When my brother, Aidan, and I took over controllership for Bryan we requested expenditure receipts and for a very short time these were supplied. After a few months we were informed that MAH would no longer supply expenditure

receipts and when we explained that we required these for the Court of Care and Protection, we were told that we should just give them the receipt provided for depositing the money to MAH. We therefore found it impossible to keep track of what Bryan's money was being used for. We felt that generally staff were truthful and honest but we had no way of knowing for sure. 15:46

Our family did have a concern with the ability to access and use Bryan's money. MAH staff might have bought things that were not for Bryan's benefit. A member of staff, whose name I do not recall, suggested to our brother, Aidan, that Bryan's money would need to be topped up as she had purchased an expensive aftershave for him costing around £80 and his money was running low. We did not see this staff member again after this incident, nor was there any evidence of it being purchased. I found the whole thing unusual as family always provided toiletries and clothing for Bryan. 15:47 15:47

My brother Aidan and I took over Bryan's financial affairs as financial controllers in 2014 when our mother became ill. I requested financial statements from the Belfast Trust up to and including the final closing statement for 2014. At that time Bryan's account with the Belfast Trust inexplicably had approximately £1,000 in it. The financial documents 15:48

provided by the Belfast Trust included a transaction account kept by MAH. It was all recorded using codes so I could not see how his money was being spent. Aidan and I had the Belfast Trust account closed. We opened a new bank account for Bryan that Aidan and I have control of. Since then the only money held at MAH for Bryan is the £100 float on the ward which our family top-up as required and the £15 per week that Bryan receives along with other patients as payment for their day care. 15:48 15:49

Since Aidan and I took over managing Bryan's finances he has significantly more money in his account. This has made me concerned that Bryan's money was previously being used inappropriately by staff members. 15:49

The standard of record keeping at MAH is very concerning. Many of the remaining patients in MAH have been there for some considerable time and yet the existence or accuracy of the historical data is questionable. 15:49

I refer to an e-mail sent to me by Dr. H223, dated 9th January 2023, at Exhibit 11, in relation to the issue of accurate record-keeping and Bryan's fit for discharge date, wherein he acknowledged the only actual letter that could be identified was from 2004 which stated he was then being considered as a delayed discharge. It further stated that on the PARIS 15:49

electronic record his delayed discharge date is recorded as commencing on 31st July 2019. The letter confirms a number of patients were given this same date of delayed discharge as the then Clinical Director, Dr. H225, was trying to formally clarify the hospital status of all patients on site at the time.

Dr. H223 is clear that, notwithstanding the record, Bryan must have been deemed a delayed discharge patient before the date 31st July 2019 which has been ascribed to him by MAH. This is a concern as I am aware that a delayed discharge date indicates a failure in the Belfast Trust's obligations which has clearly been ongoing for far longer than 2019.

Matters are either incorrectly recorded or not recorded at all. I have intentionally used recent examples to avoid any suggestion that: 'This no longer occurs since the abuse came to light in 2017.' I refer to the case review with family re referrals dated June and August 2022 that I attach at Exhibit 12 relating to the incidents from 28th to 29th June 2022 and 3rd August 2023 that found both the quality of the recording and level of observation wanting. It also found that the Datix incident report and the electronic records do not appear to shed light on the cause of the injuries and do not match the report of redness on the forehead as outlined on the body map.

At one stage Bryan's consultant, Dr. H223, was off on long-term sick leave. We were unaware of this until someone mentioned it during an MDT meeting. When I asked why the family had not been told and made aware of who would be covering for Dr. H223, I was more or less accused of interfering in staff's private business and told there was no reason why we should be given this information. I tried to explain that I did not want to know anything private but as Dr. H223 was Bryan's consultant I felt the family should have been told that he would not be present for a protracted period and told who would be responsible for Bryan's care during this period. 15:52 15:52

To counter the MAH record-keeping deficiencies and to be able to best advocate for Bryan, I have kept detailed notes of all matters relating to him. This has allowed me to compare the accuracy of MAH minutes of meetings that I have attended with my own record. A recent example is that during the meeting of 24th January 2023, five additional protections were agreed for Bryan, including that staff would be placed in Bryan's bedroom at night to observe him, however, these are all omitted from the minutes. 15:52 15:53

I am aware that Bryan should have a body chart completed twice daily, morning and evening, with a separate body chart being completed if there is a specific incident. ASG has been unable to produce the 15:53

body chart for the incident on 31st January 2023 to 1st February 2023 where Bryan sustained an injury that remains unexplained by MAH.

I am concerned about the implications of inaccuracies in notes on matters in which I have no direct involvement and, therefore, I do not have my own notes. As a trained nurse, I know the significance of record-keeping. 15:54

Going back some years when we first attended Bryan's resettlement meetings, or review meetings, there was always a clerical person in attendance to take minutes. At some stage, I am unsure when, this stopped and no minutes were distributed to family members. When I asked the reason for this, the response was vague, referring to something about cutbacks. I felt unhappy about this situation as it meant family members did not have an official record of what was discussed at meetings. I have frequently raised this issue with little satisfaction. Latterly, it is hit or miss as to whether minutes are recorded or not. In my opinion it has also aided the alteration or inaccurate recording of facts within patients' notes. If one was sceptical one might think that the Trust preferred there not to be a record of meetings for their own reasons. 15:54 15:54 15:55

In 1997 Bryan's consultant advised us that Bryan was medically fit for discharge from MAH. Our mother was

still alive and we breathed a sigh of relief when we were told that Bryan was at long last fit for discharge. We had originally been led to believe by MAH that Bryan would return to the family home with support. Not only am I trained nurse but my sister, Annemarie, is also a trained nurse and we believed that it would have been feasible for the family to look after Bryan with support. So, when we were told that Bryan was medically fit for discharge, we thought this meant he would be able to return to the family home and once again be cared for by his loving family. However, it was made clear that this was not an option and Bryan would be resettled in a facility in the community. This was about nine years after his admission. We never thought that it would take approximately 26 more years before a suitable placement would be secured for Bryan. 15:55 15:56 15:56

In or around 1997 a placement was identified for Bryan in Woodford Park, a home in Coleraine. I went with my mother to view it. The location, property and staffing of that placement were all inappropriate for Bryan's needs. Bryan required 24/7 supervision which required a high staffing level, but there were only two staff members available at night between three houses. It was remarkable that the Northern Trust should ever have regarded it as a suitable facility. When our mother indicated that this was inappropriate to the Northern Trust, she was told by H545, a social worker for the 15:56 15:57

NHS CT, that Bryan would be dragged out of MAH if we did not agree to the placement."

CHAIRPERSON: Could you just pause for a second?

A. Yes. 15:57

CHAIRPERSON: We have been going a long time. Are you okay? I am just looking at the stenographer, we've got about eight minutes' reading?

STENOGRAPHER: Yes, just keep going; that's fine.

CHAIRPERSON: Yes, okay. Sorry to interrupt you.

A. That's okay.

CHAIRPERSON: All right, you are on paragraph 104. "After the first suggested placement was identified as inappropriate, others were suggested which were also unsuitable. Then in 2015 a placement was suggested at 15:58 a facility on the Cushendall Road in Ballymena. This was next to a main road and an industrial estate. Both resettlement officer and our family agreed that this was inappropriate.

15:58

On 26th January 2017 Bryan was transferred to Causeway Bungalow in Bohill, Coleraine on a trial basis. On the first day he settled in well and his return that night to MAH was cancelled. I recall that a wonderful nurse, called H529, from MAH stayed with Bryan at Bohill for 15:58 two nights to ensure that he settled in well. Bryan remained at Bohill until the placement broke down five weeks after his admission. He had some good days there and some bad days. However, the placement broke down

in or about March 2017.

I had repeatedly asked the staff at Bohill whether they would be able to cope with Bryan's complex needs, as he had been prescribed a new medication, the effects of which were similar to dementia. I was always assured by staff that they would be able to cope. The placement broke down as the manager of Bohill, Yvonne Diamond, stated that they were not able to cope with Bryan's behaviours. 15:59

We had a meeting with the Bohill managers on the Monday morning. It was decided to delay making any decision until it would be discussed at his resettlement meeting on the Wednesday. On the Monday afternoon I was shocked to receive a telephone call from H186, resettlement officer in the Northern Trust, to say she was sorry to hear that Bryan had been moved back to MAH. We had not been informed. 15:59

There was a resettlement meeting at MAH on 17th May 2017 with discussion of a facility being built at Castledawson with secure gardens. Our family was not in favour of this location as it is very far from our home and would make visiting Bryan very difficult. 16:00

From the outset, we have advocated for an appropriate place for Bryan to be resettled that is relatively close to our family to allow for daily visits to

continue. Our daily visits to Bryan in MAH involve a 100 mile round trip which we have willingly made since he was admitted in 1988 but we are conscious that we are all getting older.

16:01

In or around December 2018 a placement for Bryan was suggested at Ballyloughan Heights in Ballymena operated by Praxis. Our family thought the suggested placement was very appropriate for Bryan. However, the project was abandoned following complaints by neighbours about noise and the option of placing Bryan there had to be withdrawn. 16:01

As a family we had been meeting with the resettlement team at MAH to find Bryan a suitable placement where he could be resettled in the community. We stopped attending these meetings out of frustration and exasperation at the lack of effort on behalf of the Belfast Trust to find Bryan suitable accommodation..." 16:01

16:01

Sorry, can I just - that isn't correct. It wasn't the Belfast Trust, it's the Northern Trust."

CHAIRPERSON: Thank you.

A. :

16:02

"... a suitable accommodation in the community. We were utterly discouraged by having obviously unsuitable placements proposed to us as options for Bryan.

In January 2021 after a long period of work with Bryan's consultant, Dr. H223, it was established that our family would be included in the MDTMs. As a result, major decisions about Bryan's care cannot now be taken without our involvement. This helped for a time but Dr. H223 now says that he cannot do this any more because he has taken on an extra role. We now get a weekly update by telephone from Dr. H223. The only contact that we get from the ward now is if there is an injury to Bryan. 16:02

At an MDTM on 16th September 2021 we agreed to consider a resettlement placement for Bryan at Braefield Manor in Ballymena. We visited the apartment proposed for Bryan in Braefield. We regarded the apartment suitable for Bryan, subject to issues concerning the installation of CCTV and the recruitment of suitably trained staff who could provide him with the consistent level of care he requires to keep him safe. 16:03

Whilst the Northern Trust and Gold Care, who own Braefield, were prepared to install CCTV in the common areas and Bryan's sitting room, they were not prepared to install a camera in Bryan's bedroom or bathroom without a court order. I made an application to court on 30th September 2022 with the hope of obtaining a best interests declaration and a deprivation of liberty order for the installation of CCTV in those areas. The concern that my siblings and I had for Bryan's safety 16:03

was that he had sustained injuries in MAH that were only explained by viewing the CCTV. Even with the installation of CCTV in MAH, Bryan continued to have injuries that staff were unable to explain, some of which were occurring in areas not captured by CCTV, such as his bedroom.

These proceedings remain ongoing and it is hoped that they will be resolved by the end of this year. In the meantime, and by way of preparation for a successful transition, Braefield staff are required to progress inreach work with Bryan following which there will be a period of transition when Bryan will be gradually introduced to Braefield.

We have travelled the length and breadth of Northern Ireland looking at facilities to find what we felt would be as close to perfect as possible for Bryan. We do not regret spending this time. We would do anything to provide Bryan with the best life possible, but we feel that the Trust has wasted our time and Bryan's life when they could have made this possible so many years ago.

We, as Bryan's family, and advocates, feel totally let down on his behalf by the length of unnecessary time he has had to spend in MAH and then to discover that he has been exposed to abusive and inhumane treatment by some of those who came across as the most kind and

caring individuals is the worst kind of betrayal. No one, and nothing, will ever be able to make up for the many years of Bryan's life which have been lost in this terrible system and the most devastating part of it all is the fact that we now have discovered that some of those who appeared to be the most caring and wanting to do good for Bryan, have now been charged with abuse. 16:06

I do not know if my brother is safe. Going on recent events I do not think he will be safe. The CCTV in MAH has not been able to provide an explanation for some of the injuries Bryan sustained. I think it is obvious that if a staff member wishes to harm a patient, then there are well-known and obvious areas that are not captured by CCTV. Even with draconian measures, such as placing staff in his bedroom overnight and keeping the light on, he was nonetheless able to be injured and staff were unable or unwilling to explain it. 16:06 16:06

Bryan appears to have very little quality of life in MAH and given that we have no control over when he will ultimately be discharged, I find it very distressing. 16:06

When the abuse was uncovered in 2017, things were dire in MAH. There was an initial scramble by the Belfast Trust to change and improve the situation. New management was recruited, however the staff turnover rate continues to give rise for concern. Things did improve in some ways but, unfortunately, that momentum 16:07

has not been sustained and currently things are still far from ideal in MAH.

Agency staff were introduced temporarily to fill the void left by suspended staff, or those leaving. Unfortunately, most of those agency staff were from mental health and not learning disability backgrounds. Therefore, through no fault of their own, they were charged with providing good quality care to people with severe disabilities and very complex challenging behaviours for which they had not been given the knowledge and skills to do. This has, I feel, led to a less than ideal level of care for the people who remain in MAH. One only has to look at the numbers of agency staff whose services have been dispensed with to see that this has not been a success. Some do provide a good service, but this appears to be the exception rather than the rule.

16:07
16:08
16:08

Since the discovery of abuse in 2017, those families whose loved ones were in the wards covered by the tight remit of the PSNI investigation have, rightly so, been given family liaison officers, mental health support and counselling. We, and other families, also have a loved one who has been abused. However, because they were in an area of MAH not covered by the investigation, or their ward did not have CCTV, we have not been provided with any of these things. We have been left sitting on the periphery looking in and having to struggle to make sense of what has happened

16:08
16:09

without any support.

I cannot adequately express the distress, trauma and damage which these events have caused to patients and their families. It is grossly unfair that some families have been forgotten about. Also, because a patient was not in a ward covered by this investigation, their abuse seems to be treated as less important and forgotten about. 16:09

We come to this Inquiry to provide evidence about Bryan's admission to MAH. The attempts to resettle him and our experience of dealing with MAH and the Belfast Trust in trying to keep him happy and safe for over 35 years. We hope that it will make a difference and provide some sort of justice for Bryan and others in MAH who have suffered at the hands of the system and perpetrators of this abuse. 16:10

It will never make up for or remove the awful experiences they have been through but if it prevents the same thing happening to one more person, we will be content. We as a family want Bryan to be independently assessed by an expert to determine what abuse he has suffered, what effect it has had on him and how he should be cared for as a result. We also want an independent expert to review his medication. We, as a family, want accountability on all levels. 16:10

Over the years, I have regularly attended meetings, written letters, complained to management and the PSNI, I also wrote to Richard Pengelly on 24th August 2019 and Minister Swan in March 2020. I have attached copies of these letters at exhibit 13. I have done all that I can to draw attention to what has happened in MAH on behalf of Bryan, as his sister, and in the interests of other patients and their families through SPFM. I did not readily reach the conclusion that there was systematic abuse in MAH but the evidence became inescapable and I was clear that change was and is required. 16:11 16:11

The entire system must change, mindsets must change, and people with learning disabilities must be viewed as valuable members of society in their own right, instead of lesser beings who do not feel pain or are just there for other's amusement. If this mindset is not changed then abuse will not end with the planned closure of MAH but will continue in other institutional settings. 16:11 16:12

The Belfast Trust and other agencies, such as Adult Safeguarding, RQIA, PSNI, HSENI, and other professional bodies must share the awful blame for ignoring and allowing the continuation of these terrible abuses. It is incumbent upon them all and this Inquiry to ensure that a repetition of these events cannot and will not happen again. It has suited Belfast Trust to allow MAH to remain a place apart and for these vulnerable people 16:12

to be kept out of the public eye. Also for families to be actively discouraged from participating in their relatives care by telling them that the professionals know best and can provide best care.

16:12

Families should be encouraged to interact with others rather than being kept apart. Only if all these things are taken on board, changed, and actively pursued will care in the future look better for our loved ones and allow them to live brighter much enriched lives. We owe it to them all. "

16:13

MR. DORAN: Thank you, Brigene. Chair, I wonder do you wish to take a short break before questions commence? It has been a long read.

16:13

CHAIRPERSON: It slightly depends. Do you have questions to put? It is a very comprehensive - if I may say so, it's one of the most comprehensive statements I think we've had. But do you have any questions you want to put or do you want to have a few minutes to think about it.

16:13

MR. DORAN: I'll maybe have a few minutes to think about it, Chair. Perhaps the Panel could proceed with their questions in the first instance and I may follow.

PROFESSOR MURPHY: I don't have any questions. I think it was a really thorough statement.

16:13

A. Thank you.

P90's SISTER WAS THEN QUESTIONED BY THE CHAIRPERSON,

AS FOLLOWS:

CHAIRPERSON: I have just got two little things. One is just a clarification. If you go to your paragraph 38 again, and I am being a bit pernickety, but you say over the page, at the top of page 11, do you see where you say: 16:14

"These activities not happening. We have been told that this is because of a staffing crisis."

16:14

You say:

"I received a letter on the staffing crisis dated 18th March."

16:14

A. Yes.

CHAIRPERSON: "...which are attached as exhibit 3."

If we look at exhibit 3, which is at page 46, if you look right at the top of the pages. I wonder if the Secretary to the Inquiry can help? We are just finding page 46. 16:14

SECRETARY: The exhibits aren't with --

CHAIRPERSON: We can put it up. There it is. Excellent. Thank you so much. Well done. If you just scroll down to the bottom of the letter, keep going, it is actually from you? 16:15

A. Right.

CHAIRPERSON: But I just wanted to --

A. Yeah.

CHAIRPERSON: -- so it looked as if the staff had written - as if somebody had written to you about the staffing crisis?

A. Yes. 16:15

CHAIRPERSON: Actually, it is you raising the issue; wasn't it?

A. That's not actually the letter I am referring to there. The letter I am referring to was a letter that I received, and I assume all families received, from the 16:16 Belfast Trust regarding the staffing crisis in the hospital. This letter in the exhibit, from what I can see here, is a letter that I wrote to the Department of Health, which I presented to them at the MDAG meeting regarding the staffing crisis because my thinking was 16:16 that they were the people who after the crisis broke, they were the people who provided the means for the agency staff to come to cover the hospital. So, therefore, to me it was partly their responsibility to make sure the staffing crisis in the hospital was 16:16 resolved. I felt the best way to do that was to raise it at the MDAG meeting and to read this letter to them.

CHAIRPERSON: I'm glad we've got that letter. We better have the other letter as well. It may well be that we've got it somewhere and I will make sure it is 16:17 produced.

A. Okay. Thank you.

CHAIRPERSON: So apologies for that but it is useful to explore that with you. Finally just this, the carers'

forum that you mentioned.

A. Yes.

CHAIRPERSON: That was something set up really for people like you to have a meeting point but you seemed to rather felt it got hijacked in the end. Is that right? 16:17

A. Yes, originally I along with - if I can find her, I can't find her name now.

CHAIRPERSON: It is actually in paragraph 49.

A. Yeah, I at that time the Director, the Interim Director for learning disability in the Belfast Trust at that time was actually positioned in Muckamore Abbey Hospital because of the crisis and things that was happening. 16:17

CHAIRPERSON: Yeah. 16:18

A. And I formed a good relationship with her and done a lot of work with her around what families were telling me was their problems and issues. Together we discussed it and we decided, and I advocated very hard, for the implementation of a carers' forum because it was very plain, as I have stated somewhere in the statement, that there seemed to be this culture of divide and conquer. 16:18

CHAIRPERSON: Yes.

A. Not allowing families to have any sort of coming together or communication between the families. So we felt that this would be a good communication tool whereby if we could limit to the minimum the number of Trust staff who would attend these meetings that family 16:18

members would feel freer and more able to open up and bring forward issues that they had so that something, those could be taken forward to the relevant person in the Trust and hopefully resolved.

CHAIRPERSON: And engage with each other presumably? 16:19

A. Yeah. So then H287 a short time after that left the position. I don't know whether she retired or was removed or whatever else. So there was new management brought in and that repeated itself three, four times, the management has been constantly changing ever since, 16:19 but the new management decided that they would hijack the meetings. So it became gradually more and more management from the Trust attended the meetings.

CHAIRPERSON: Okay.

A. And every time a family member raised an issue that 16:20 they wanted to bring forward to have something done about it, management would say: 'This is not the place to raise these things', when in actual fact that was actually what the carers' forum was for.

CHAIRPERSON: So at the beginning, did it work 16:20 reasonably well?

A. It worked really well at the beginning and until that started to happen things were going really well and lots of issues did get resolved but more and more people were bringing problems and concerns to the fore 16:20 and those things were either being brushed under the carpet or they were not being resolved. People were told: 'I speak to you outside of this meeting', but nobody ever came back to them. Therefore, the family

members gradually dwindled off because people felt there was no point in them coming because they were getting nothing resolved and they were actually being put down rather than being listened to. So that's why people --

CHAIRPERSON: I've got it --

A. At this minute in time I am the only person, the only family member really that attends those meetings.

CHAIRPERSON: So they are still going on?

A. Yeah. 16:21

CHAIRPERSON: All right. Mr. Doran, do you need a break or you have thought about whether you have got --

MR. DORAN: I have thought about what I would like to ask, Chair. Just a few matters.

CHAIRPERSON: Yes, of course. Five minutes and then we'll definitely take a break. 16:21

P90's SISTER WAS THEN QUESTIONED BY MR. DORAN, AS FOLLOWS:

MR. DORAN: I am very conscious that the witness hasn't had the opportunity of displaying the photographs of Bryan and maybe we could do that just now? 16:21

CHAIRPERSON: Yes, of course.

MR. DORAN: I think it is important, Brigene, that you have a chance to talk us through them. 16:21

A. Yes.

110 Q. The first one is at page 36 I think?

A. Okay, this is a photograph of Bryan at one of his birthday parties in Muckamore, probably maybe four or

five years ago with myself and my husband, my brother Aidan and his wife and their daughter and my other brother Paul. And I mean that was basically what we done, we would bring a cake and presents and he would blow out his candles and we would sing happy birthday. 16:22

111 Q. Yes.

A. Do the general thing because Bryan doesn't like a long-drawn-out party. It's short and to the point because he doesn't do things for a long time.

112 Q. Yes. 16:22

A. He was enjoying his birthday there.

113 Q. Brigene, I was going to ask was it Bryan's birthday yesterday?

A. Yes.

114 Q. And did you manage to have a bit of a party? 16:22

A. Yes, we did. We had the usual, taking presents, sing happy birthday, blow out your candles, eats lots and lots of food that you shouldn't be eating. He genuinely enjoyed it. We actually managed to spend two hours with him yesterday. He was fairly happy and 16:23 enjoyed his time and, as I say, scoffed plenty of flood. So, yes.

115 Q. I am very glad to hear that. On page 37 then you have provided us with a photograph of Bryan?

A. Yes. 16:23

116 Q. When was that one taken?

A. That I think was taken, I can't say exactly, but it's since July 2021 because that - he was just moved to that ward at that time.

117 Q. Yes?
A. So that was sometime in later '21 or '22. It just shows him sitting in the open area of the ward at a table and you can see what is on the table there beside him is, there is various like sensory toys that he has been doing an activity with. It's not a great photograph but he looks fairly happy there. 16:23
118 Q. I think the next two photographs go back a bit further in time then?
A. Yeah, slightly. That's a picture of Bryan with myself and our mother at my wedding. And what we actually managed to do, and we actually done the same thing for Aidan's wedding, we managed to get arranged that Bryan would be taken on a bus trip and the bus trip, part of it would be that he would pop in to where the wedding reception was and we managed to get some photographs of him with the family at the wedding and then he went back to Muckamore again, which wasn't really what we wanted but it was the best we could do. 16:24 16:24
119 Q. Then the final photograph, Bryan looks very young in that one? 16:24
A. This photograph is the family's favourite and it is one that each and every one of us have hanging in our houses at home. It's actually a portrait photograph which was taken by a professional photographer when Bryan was 17 and it really portrays how normal Bryan appeared before he went to Muckamore compared to what his face actually looks like now through all the self-abuse that he has done to himself, banging his 16:25

head and stuff like that. In actual fact somebody commented that they looked like a professor there, but it is about the best photograph we have of Bryan.

120 Q. I know that your brother Aidan has exhibited that photograph as well to his statement? 16:25

A. Yes.

121 Q. You've been visiting the hospital for many years now, since 1988 I think?

A. 88, mhm-mhm.

122 Q. What's clear from the statement is the sheer level of devotion that your family has to Bryan? 16:26

A. Yes.

123 Q. And I think you say in your statement that your mother was afraid what Bryan might forget the family?

A. Yes. 16:26

124 Q. Someone went every day to see him?

A. Yep, Bryan's brain injury means that he has a very short attention span and short memory span. So that means that things like activities have to be done with Bryan in short bursts, 10, 15 minutes, at most half an hour because otherwise he just disengages. So, likewise, if Bryan doesn't see a person for a long time, or doesn't have something happen for a long time Bryan will ultimately forget, that memory will leave him. So mammy's great concern was that when he was in Muckamore that if he didn't have constant contact with the family, that his memory problems would mean that after a period of time Bryan would forget who his family were. In actual fact she has been proved right 16:26 16:27

and it has been borne out because even to this day when we go to Muckamore to visit Bryan, each one of us has an individual thing that we done with him when he was at home, like I do a thing with his nose somebody else does something else with him and somebody else counts with him. Even now to this day whenever we go into Muckamore to visit him and we do those things with him, he remembers that. And also when we go in the front door if we are talking to the staff, even though he can't see us, if he hears our voices he will actually get up and come, he knows who it is, recognises the voices and will come to meet us. That, as I say, is the only reason why we've continued with the Zoom calls because we've found that they are not really, they are not really great for Bryan because he can hear the voices, he recognises the voices but he has no concept of you are in that square box, you are not here with me. And sometimes you can see him actually looking around as much as to say where's the voice coming from. I can't see you. So that's why we, as a family, continued to visit every day. 16:27 16:28 16:28 16:28

125 Q. Just one last thing, Brigene, presumably given Bryan's particular needs it is important that those working with him know him and have an understanding of those needs? 16:29

A. Yeah, absolutely, and it is written in his care plan that Bryan is to be supervised and looked after by familiar, staff who are familiar to him and staff who he is familiar with and that is why I had put in my

statement about the unfamiliar staff that were brought to look after him. You know, because that is one of the triggers for his challenging behaviour. If he is faced with people he doesn't know it can trigger off that behaviour. So, as I say, it is written into his care plan that the staff should be familiar with him.

126 Q. You express particular concerns about agency staff passing through and maybe not knowing him that well?

A. Yeah, absolutely. You know, and we have found as well that a lot of times when we went to visit there would be like a collection of staff all gathered together having their own sort of conversation, but it would be close enough to Bryan that it could trigger off his behaviour because too many people crowding around him, he doesn't like that either and too much noise. So you could find sometimes there is a lot of staff, a lot of raucous laughter and loud noises and stuff and we found those trigger off his behaviours as well, so those are things that have to be kept --

16:29

16:29

16:30

127 Q. Brigene, just finally you have presented a lot of detail to the Panel and you are a person with a vast experience of the hospital and also a qualified nurse yourself?

16:30

A. Yes.

128 Q. Before you finish your evidence is there anything else that you would like to raise with the Panel?

16:30

A. I suppose it is so extensive really, I have put most of it in there. But I would just like to say that since all this has happened and things have been happening to

Bryan, I have found it personally distressing. Apart from the fact that Bryan is my brother, I feel some kind of shame that this has been perpetrated by people of my profession. I would never think I am perfect but I would like to hope that I would never treat anybody in the way that the people in Muckamore have been treated by professionals who are supposed to be caring. I find it extremely distressing. As I have already said in my statement, I do hope that what will come out of this Inquiry will be that there will be a better system. As I have said, and I am a great advocate, I know privacy is important but I just feel that in this case safety overrules privacy and I do feel that there should be pan coverage of CCTV in care homes, hospitals, where people who have not got the capacity to tell what's happening to them, that that should be provided because it has been proven time and time again that if you don't have pan coverage there is still the risk of it being open to abuse because people know where there is no coverage. So I do hope that your recommendations will provide for a better system to be put in place and we, as a family, hope that whatever comes out of this that people will be held accountable, not just those who done the perpetrating of the abuse but more importantly in my mind is those who managed them and those who knew about the abuse and ignored it, let it go on for longer than it should have been allowed to go on. And, you know, I do feel that the more management and higher up members of the Trust did

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know that there was abuse going on because, for instance incidents of seclusion, as far as I am aware, have to be signed off by a doctor. So in that respect alone the doctors and medical staff should have known how many incidents of seclusion were happening and they 16:33
also should have been able to provide justification for why those people were put into seclusion. I also feel that the statutory agencies have failed miserably in Northern Ireland over the past few years in respect of protecting the vulnerable people in Muckamore. I know 16:34
personally that I have spoken to every single one of them on various occasions and have been told that things will be looked into et cetera and things just didn't change, it just didn't change. So my wish is that there will be a better new system for looking 16:34
after the vulnerable people in Northern Ireland and that somehow we can manage to get to an era where the care provided to them will be better. And, as I said, please, somebody help us to get these people to be viewed as valuable members of the public, the same as 16:34
anybody else. You know, I just feel very strongly that if someone was doing to another person on the street what these people have done to our relatives in a hospital they would be charged, they would be taken to court, they would be jailed, whatever. But because it 16:35
is in a hospital or care setting it seems to be completely different, and people are not held accountable.

CHAIRPERSON: All right, Brigene, can I thank you very

much. The quality of your statement I suspect reveals something about your training as a nurse because it was a very full and comprehensive account. And it has also been obvious how devoted not only you are individually to Bryan, but also your family and I want to pay tribute to them perhaps as well. So can I thank you very much for coming to assist the Inquiry, you can now go with Jaclyn, the secretary to the Inquiry. 16:35

A. Thank you.

CHAIRPERSON: We were going to read two statements this afternoon. I can allow one of them to be read. I think it's too much I am afraid, we started at 9 o'clock this morning and I think for the stenographer particularly, it is just too much. 16:35

MR. DORAN: I agree Chair. Can I say that the other witness is P90's brother. 16:36

CHAIRPERSON: What I was going to suggest, we take a 10 minute break, we deal with Bryan's brother and then we will sit again at 10 o'clock and have the last statement read. I wanted if I could to devote tomorrow to out of terms of reference summary but I don't think it will make too much difference to have one statement read in the morning. 16:36

MR. DORAN: I respectfully agree.

CHAIRPERSON: 10 minutes. Thank you. 16:36

THE HEARING ADJOURNED FOR A SHORT PERIOD

THE HEARING RESUMED AS FOLLOWS:

MR. DORAN: The next witness is Bryan's brother, Aidan.

P90'S BROTHER HAVING BEEN SWORN WAS EXAMINED BY MR. DORAN AS FOLLOWS:

CHAIRPERSON: Aidan, could I just welcome you to the Inquiry, thank you very much for coming along. I think you were sitting in the public gallery.

A. I was sitting there, yes, as usual. 16:51

CHAIRPERSON: While your sister was giving evidence. All right, so thanks for coming to assist the Inquiry.

A. Not at all.

CHAIRPERSON: I'll hand you over to Mr Doran.

129 Q. MR. DORAN: We have met before? 16:51

A. Yeah, many times.

130 Q. Yes indeed and we had a brief chat earlier on before your evidence. You were sitting during Brigene's statement and evidence and you will be aware that she covered a lot of ground. So it may be that I won't be 16:51 asking you questions after your statement but I am going to read it in and give you the opportunity to add to it if you wish. I am conscious that this is very much a statement on behalf of the family and not just yourself. I think you mentioned that to me earlier. 16:52 Now, you made your statement on the 30th of August of this year about Bryan's care at the hospital; isn't that right?

A. Yes.

131 Q. So, I am going to read in now and then, as I say, offer you the opportunity to correct or add anything you would like?

A. Okay.

132 Q. "I, Aidan, Bryan's brother make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. In exhibiting any document I will number my documents so my first document will be exhibit? 16:52

A.

Indeed, Aidan, we dealt with the exhibit 1 which is the old photograph of Bryan. 16:52

A. That's right.

133 Q. "My connection with MAH is that I am a relative of a patient in MAH. My brother Bryan is currently in MAH and has been since 1988. The relevant time period that I can speak about is 1988 to date my brother, Bryan, is 56 years old and has been an in-patient in MAH for 35 years. Bryan is a vulnerable adult who has severe learning disability. He has a diagnosis of bipolar disorder and autism. Bryan lacks capacity and is non-verbal. Bryan has hardly spent a day without seeing our mother or one of his siblings, except for the initial 12 weeks following his admission to MAH in 1988 and during the Covid 19 lockdowns. Bryan is at the very centre of our family. Since we became aware of the abuse at MAH it has been an almost full-time job to try and keep him safe and maintain his wellbeing. This has included coordinating and rostering our holidays to ensure that Bryan has a daily visit from at 16:53 16:53 16:53

least one of us. This involves a 100 mile round trip which we willingly do.

I have been with my sister, Brigene, on many of her visits to see Bryan at MAH and I also visit Bryan on my own. 16:54

Over the Covid 19 lockdown periods our family still went to see Bryan but we could only see him through the window at a safe distance. I went to see Bryan around three times like this. I found it very difficult to see Bryan for just a few minutes like that. I am not sure what Bryan would have made of it, but I hope that it helped him to at least see our faces. 16:54

Our family visited Bryan like this because we could not rely on the staff to provide us with a proper updating telephone call. We find it difficult to get in contact with staff as the phone goes unanswered and when we do speak to a member of staff for an update it often feels as though they are reading from a sheet. We also could not rely on Zoom calls. These were always problematic because of the poor quality of internet connection. Bryan also seemed to find it hard to concentrate on the screen and would wander off. 16:54 16:55

During Bryan's time at MAH, including during the lockdown and isolation periods, our family has been constant in providing Bryan with money, treats,

personal hygiene items and clothing.

our family is exceptionally close. After our parents passed away, my siblings and I have dealt with all issues concerning Bryan, including his resettlement. I 16:55
have fully participated in the effort to have Bryan resettled into the facility at Braefield Manor, Ballymena, and I have attended court hearings for an application to have CCTV installed.

16:55

I have read Brigene's instructions on the evidence that she can provide and I agree with it, however I wish to address certain specific issues regarding Bryan with which I have had direct experience.

16:55

Whilst Bryan has had challenging behaviour for his entire life, it was never anything that alienates him from us. Despite Bryan's challenging behaviour before he went to MAH at the age of only 21 years he had a good and happy life, he did things, met people, and was 16:56
known in our community. I refer to Exhibit 1 which is a photograph of Bryan from the period before he was admitted to MAH.

Our family wanted and hoped that MAH would provide a 16:56
better understanding of Bryan's behaviour and the means to help him, so that he could live his best life. We trusted that when Bryan was admitted to MAH that as a specialist psychiatric facility it would use the

experience and expertise of the psychiatrists and nurses to help him. We believed that MAH would be able to keep him safe whilst they were diagnosing what caused his challenging behaviour and how best they should be managed. 16:56

I cannot believe that Bryan is 35 years in MAH a psychiatric hospital environment, with some very challenging patients and where Bryan has been regularly subject to abuse, as detailed by my sister, can 16:57 possibly constitute his best life. Our family has done all we can to maintain Bryan's link with a world outside MAH and let him experience the love that we have for him.

16:57

I still cannot believe that Bryan's experience for the last 35 years is the best that Northern Ireland's main psychiatric hospital could offer. I also cannot believe that after Bryan was finally deemed medically fit for discharge in 1997 after nine years in MAH it 16:57 has taken the Northern Trust a further 24 years to identify a suitable placement for him, during which time Bryan has suffered abuse.

I visited Bryan with my mother for decades. It was 16:57 only recently that we were shown Bryan's room. In all the years that we were going to MAH we always visited him in a small visitor's room. We trusted the staff for so many years and gave them the benefit of the

doubt. My sisters, Brigene and Anne-Marie, are trained nurses. Brigene was also heavily involved in the Society of Parents and Friends of Muckamore Hospital. They believed that whatever the difficulty of dealing with patients who were mentally ill or who had serious learning disabilities, MAH would do its job with best interests of the patients in mind. 16:58

when I heard about the abuse I was horrified. I cannot even put it into words. I regarded it as the grossest breach of Trust. Staff could be so pleasant to your face but behind the scenes they knew what was happening. Our family feels so betrayed. Apart from some good individual nurses who gave us information we would not know anything about Bryan's care. I think it is important to mention that there were some brilliant nurses in MAH. Many of the nurses did their best. The nurses who are still there are a credit to their profession. The difficulty I have with staff is the management. They had the power and could set the culture. I do not know how the nurses who inflicted the abuse were allowed to continue with their abuse for so long. I feel that management spent too much time either refusing to properly manage a place where abuse could easily occur or trying to avoid blame. 16:58 16:58 16:59 16:59

Our family have been on-call for Bryan's care 24/7, even though we all have families and are trying to lead our own lives. We have a lifetime of experience with Bryan but we cannot recall ever being asked how to

manage Bryan's challenging behaviour in all the 35 years he has been a patient in MAH. I find this shocking.

Bryan's safety is our main concern. The Trusts still do not care about Bryan or our family. Management has always been the problem and the fight we had to remove Bryan from MAH has been incredibly difficult for us. Bryan has been destroyed by his time in MAH. I query what the Northern Trust have been doing for the past 35 years. I blame high level management who call the shots, and do not have any consideration for our family. 16:59 17:00

There was never great communication with management in MAH, my sister, Brigene and I were invited to multidisciplinary team meetings (MDTMs) on a few occasions but our invitations dwindled off. We were faced with obstacles rather than solutions and in the end it was pointless. Our family wanted to have an active role in the care of Bryan. The voices and concerns of our family have not been taken into consideration. The only recourse for our family in relation to Bryan's proposed resettlement facility has been through the courts. This is unhelpful, stressful, and onerous on top of our caring responsibilities. I am hopeful that the MAH Inquiry will be able to find out the truth of what happened in MAH and who was responsible, especially within management. Families 17:00 17:00

have so much stress and anxiety from their loved ones being in MAH and trying to have them resettled out of it.

One recommendation I would like to see is that a Learning Disability Commissioner is appointed to ensure that, like older people and children, people with disabilities are given a strong voice to speak for them when they cannot do that or their families cannot do it for them. Individual families should not have to take to the courts to try and make sure their loved ones are kept happy and safe and that their rights are protected. Bryan has been so badly let down, he did not chose to go to MAH and had no control over how long he stayed there. He is non-verbal and relied on others. The system is flawed and allowed the abuse of my brother to continue for over three decades." 17:01 17:01 17:01

Now, Aidan, I have read through your statement. Is there anything in there that you would like to correct first of all? 17:02

A. No, Sean, everything seems quite correct.

134 Q. And are you happy to adopt that as your evidence to the Inquiry?

A. I am, yes. 17:02

135 Q. And, Aidan, can I ask, as I said earlier, your sister Brigene, has covered a lot of ground. I am not going to ask you specific questions but is there anything that you would like to add for the Panel before you

finish your evidence?

A. No, Sean, really, all along all I have really wanted is what all families want is change, recommendations made, not just recommendations made and then nothing being done about it. Somebody needs to stand up, come up to 17:02
the plate and put in place, which hopefully this Inquiry will do and I wish you well on it, that changes are made because we have, we are the people who have the opportunity now, it has been brought in front of our noses, albeit for a long time we didn't realise it 17:03
was there, now that we do we have the utmost opportunity, not only for our brother but for other people in and around disability to be recognised as human beings and not treated like animals. It is just how I feel. My frustration, I can't say anger but I am 17:03
not even angry, it is total frustration at how another human being can treat, especially the most vulnerable people who are so dependent on myself, the likes of them. And as I say my mother, God rest her, I have said before and I'll say it again on record, I am so 17:03
blessed and we are blessed that she never, ever knew what happened in that place. But, she has left us to carry on and that is what we shall do. Regardless of what comes out of this, for ourselves and for other people and relatives, as Brigene said in her statement, 17:04
it was more to keep the families apart. I can tell you there is still encouragement around that today, but that aside, we will still be there as long as we are fit to have a breath in our body for, not Bryan, but

for everyone. I just wish the Panel well and thanks for the opportunity to express what we have experienced ourselves throughout the years, it has been a long long time and I am so glad that hopefully we are at the stage now that other people are there, they are getting on board, you don't feel you are fighting a battle on your own anymore. I don't mean that in the wrong way but there is times, there is times you just have to say are thumping our heads here, we need a bit of assistance. This is where people like yourselves will come in and hopefully make recommendations and somebody will have a heart somewhere or a mindset that right, let's do this. Because if we miss this we have missed it. We have missed it for a good -- I truly believe that, you get the one chance at it, let's take it. 17:04 17:04 17:05

136 Q. Thank you, Aidan.

A. Thank you for letting me say that. I am not a great writing person, but I can put it out through my voice, thank the Lord.

137 Q. If I may say, you have made those points very forcibly, indeed. It may be that before we close this afternoon that the Panel will have some questions for you? 17:05

CHAIRPERSON: As Sean has just said there, I think the passion comes through in your voice and I paid tribute through Brigene really to you and your family for doing everything you can for Bryan. As she said, you know, you have travelled the length and breadth of the land trying to find the right place for him and it is obvious that as a family you have really been devoted 17:05

to him in a very long struggle and so we do appreciate that, we appreciate you coming along.

A. Not at all.

CHAIRPERSON: To give evidence and to assist the Inquiry so can I thank you, thanks to Brigene and thanks to you for coming to assist the Inquiry. 17:06

A. Not at all, thank you.

CHAIRPERSON: We will sit tomorrow at 10 o'clock. Thank you all very much indeed.

17:06

THE HEARING ADJOURNED