MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 14TH NOVEMBER 2023 - DAY 69

69

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

GWEN MALONE STENOGRAPHY SERVICES

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1 THE INQUIRY RESUMED ON TUESDAY, 14TH NOVEMBER 2023 AS
2 FOLLOWS:
3
4 CHAIRPERSON: Mr. McEvoy.
5 MR. MCEVOY: Chair, good morning Panel. This morning 10:03
6 the Inquiry will hear the evidence of A4. Before we
7 proceed with that evidence, there is a Restriction
8 Order application and if the application could be the
9 subject of a temporary order before I proceed.
10 CHAIRPERSON: Yes, certainly. The feed is to be cut to 10:04
11 Room B and there is to be no reporting of the
12 application until I determine the application itself.
13
14 IN RESTRICTED SESSION
15 10:04
16 IN OPEN SESSION
17
18 CHAIRPERSON: Are we then ready for the witness?
19 MR. MCEVOY: We are.
20 CHAIRPERSON: And it's to be A4 throughout? 10:07
21 MR. MCEVOY: That's right, Chair. As Core Participants
22 will see as you indicated yesterday, this is one of the
23 evidence sessions which is going to take place behind a
24 screen in order to preserve anonymity.
25 CHAIRPERSON: Yeah, okay. Good morning. 10:08
26 WITNESS: Good morning.
27
28 WITNESS A4 QUESTIONED BY MR. MCEVOY:
29

1 1 Q. MR. MCEVOY: Good morning, A4?
2 A. Good morning.
3 2 Q. A4, we met briefly this morning. My name is Mark
4 McEvoy, I'm one of the Inquiry counsel and I'm going to
5 take you through your evidence this morning. That 10:08
6 evidence can be found, can it, in a statement which is
7 in front of you, I hope?
8 A. It is indeed.
9 3 Q. And it is a statement of some nine pages is that right?
10 A. That's correct. 10:08
11 4 Q. And if you look at the last of those nine pages then
12 there is a declaration of truth and that's your
13 signature?
14 A. It is indeed.
15 5 Q. And a date then of 30th October, just past, this year? 10:09
16 A. 30th June '22.
17 6 Q. So that's on the front?
18 A. All right, on the back.
19 7 Q. The date of your signature which is the 30th October?
20 A. That's correct, yes. 10:09
21 8 Q. And you intend then to adopt that statement as your
22 evidence?
23 A. I do.
24 MR. MCEVOY: To the Inquiry.
25 CHAIRPERSON: All right. A4, as you know I've given 10:09
26 you anonymity so you will be referred to as A4
27 throughout. The first thing that's going to happen is
28 that Mr McEvoy is going to read your statement so you
29 can just listen obviously carefully to that. Then you

1 will be asked questions. When you are asked questions
2 can you just take it very slowly and I'll ask Mr McEvoy
3 to take it slowly. Because you have anonymity, it's
4 slightly different to simply ciphering names, we want
5 to ensure that neither your name nor anyone you are 10:09
6 connected with is revealed. So please take your
7 evidence slowly and thoughtfully, I'm sure you will be,
8 because I can make the order to give you anonymity but
9 you could reveal your name accidentally, so just take
10 it slowly, all right? 10:10
11 A. Thank you.
12 9 Q. MR. MCEVOY: Beside your witness statement, A4, is a
13 short document in the form of a table which is the
14 cipher key, so if it does occur to you that there is
15 possibly a name that floats to the top of your mind as 10:10
16 you're giving your evidence could you, as far as
17 possible, please, just have a glance at that first to
18 make sure that there's no cipher applying and if you
19 are in any doubt, it may be that I'll ask you to write
20 a name down if that need arises. 10:10
21 A. Okay.
22 10 Q. Okay in your statement then you begin by telling us
23 that your connection with Muckamore Abbey Hospital is
24 that your main connection is that:
25 10:10
26 "I have a sister with a severe learning disability who
27 spent two periods of approximately one year each time
28 as a voluntary in-patient in the Fintona South ward."
29

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1 You then go on to say:
2
3 "I was also a social worker employed by the Belfast
4 Health and Social Care Trust (the Trust) within the
5 Community Learning Disability Services from 1995 until 10:11
6 2014 when I became a team leader in the East Belfast
7 team. In 2016 I became an Operations Manager over east
8 and West Belfast and was the social work lead for the
9 service. In 2017, following the discovery of the abuse
10 of patients in Muckamore Abbey Hospital, I also became 10:11
11 social work lead over the social workers based in
12 Muckamore. I was a designated adult protection officer
13 within the Trust and adult safeguarding lead for the
14 service until the appointment of an adult safeguarding
15 lead for the service around 2018." 10:11
16
17 And then, A4, as I understand you give details of your
18 current employment and, as I understand it, you're
19 content for me to indicate that currently you hold a
20 senior management role within the health sector in 10:12
21 Northern Ireland?
22 A. That's correct, Chair.
23 11 Q. Then moving on to paragraph 4:
24
25 "The relevant time periods that I can speak about are 10:12
26 between 1998, 1999 and 2000 to 2001 when my sister was
27 admitted to Muckamore, and between 1995 to 2021 in my
28 role as Social Worker Operations Manager working with
29 patients in Muckamore and subsequently managing the ASG

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team and social workers in Muckamore.
I will deal with each relevant time period in chronological order.

My sister is a patient at Muckamore. My sister was admitted as a voluntary patient to Muckamore in 1998 and in 2000. My sister was born on..."

You give her date of birth.

"...and is aged 56. She has a learning disability.
"My sister has been under the care of the Northern Health and Social Care Trust and used its services from the age of 18.

In and around 1998 my sister was living in supported living accommodation. She found it difficult to cope with this type of living and concerns were raised that she may have been suffering from a depressive illness. My sister was under the care of Dr. H41 who was a psychiatrist and I believe medical director at Muckamore at that time. She was assessed and agreed to a voluntary admission to Muckamore in November 1998. This was done in conjunction with our family. My sister stayed at Muckamore for almost one year. She stayed in the Fintona South villa. She did not have a room to herself. During this time I noticed a significant improvement in my sister. The treatment she received from the nursing staff was second to none.

1 We, as her family, received a lot of support from H41
2 who kept us informed. H84, the social worker for the
3 ward worked with my sister during her stay. My sister
4 speaks fondly of staff nurses H85, H86 and ward manager
5 H12. They dealt sensitively and positively with my 10:14
6 sister's issues and communication with the family was
7 positive.
8
9 Following the treatment, which was a combination of
10 anti depressants therapeutic inputs by the nurses and 10:14
11 social worker, my sister made a good recovery and was a
12 different person to what she was when admitted. This
13 was a very positive experience for my sister and our
14 family.
15 10:15
16 Following discharge my sister returned to supported
17 living. Approximately one year later, near the end of
18 1999, my sister began to display symptoms of depression
19 again. This time Dr. H50 was her psychiatrist. He
20 accepted the family's concerns and was able to 10:15
21 facilitate my sister's voluntary admission. She was a
22 patient for almost one year. She appeared well cared
23 for. On this occasion, she had her own room with her
24 personal possessions in it.
25 10:15
26 My sister had a very positive experience at Muckamore.
27 She was very fond of a nurse called H12 and has fond
28 memories of her time at Muckamore. H12 supported us as
29 a family. My sister never raised any concerns about

1 treatment of either herself or others on the ward and
2 she would have had the capacity to do so. Even to this
3 day my sister would say that she never witnessed any
4 cruel treatment of any of the patients whilst she was
5 there. 10:16
6
7 When my sister left Muckamore in 2000 it was determined
8 that supported living accommodation was not appropriate
9 for her. She moved to a private nursing home and
10 remained there until four months ago, my sister now 10:16
11 lives with me."
12
13 **Turning then to paragraph 11.**
14
15 "I began my employment with the Trust in 1995 as a 10:16
16 social worker. I was appointed Operations Manager
17 which meant I had a professional responsibility for
18 social work staff to include those who worked with and
19 in Muckamore. I was also a Designated Adult Protection
20 Officer, DAPO, and Adult Safeguarding Lead for the 10:16
21 Learning Disability Service in the Trust until 2018/
22 19, when a lead was appointed. This was under the
23 Adult Prevention and Protection in Partnership Policy
24 2016.
25 10:17
26 From 1995 I worked as a social worker in the community
27 team in Belfast. As part of my role it was normal
28 practice to attend Muckamore to meet patients. When
29 meeting with a patient I did not have to make an

1 appointment and could attend at any time during the
2 day. I was welcomed by staff to open wards. I was not
3 aware of any nurses who experienced any issues, even
4 with what would be deemed more "dangerous" patients.
5 10:17
6 Up to and until 2012 Muckamore was under the management
7 of Dr. H41, Dr. H90, Dr. H40 and Dr. H50. My
8 experiences with them were positive. The team of
9 social workers that I worked with also had positive
10 experiences. I believe that Dr. H41 had every 10:17
11 patient's best interest at heart and a genuine care for
12 them. If she felt a patient was struggling she would
13 have let a social worker know. She engaged with us.
14
15 I began to notice a change in the approach taken by 10:18
16 Muckamore towards social workers following the
17 appointment of H507, the service manager, in and around
18 2012. I describe it as a rift as the nurses no longer
19 worked well with the community teams. Their attitude
20 changed towards social workers and the nursing staff 10:18
21 acted as if they were experts. They treated the
22 community team as if we did not know what we were
23 doing. The Community LD Teams supported over 1,700
24 users with complex needs and are very experienced
25 social workers, nurses and AHPs. Only a tiny 10:18
26 percentage of service users were in Muckamore. I found
27 that the nurses became more professional and lacked
28 warmth. Some patients had been at Muckamore for a long
29 time and considered it like their home. There was a

1 notable shift in the approach taken by staff at
2 Muckamore when dealing with patients. The new approach
3 was that patients could not stay long-term at
4 Muckamore, as it is a hospital and, although this is
5 quite right, the patients' bedrooms where they had 10:19
6 their personal possessions were stripped and the
7 environment became more sterile.
8
9 When attending Muckamore I was no longer allowed to
10 access the open ward and was brought into a room to 10:19
11 meet with patients. I was not aware of any seclusion
12 rooms at this time.
13
14 Muckamore reduced the social work team to two people.
15 Prior to this a social worker was dedicated to each 10:19
16 ward. The role of a social worker is to advocate on
17 behalf of patients. I am aware that Muckamore held
18 ward meetings and, over time, the role of the social
19 worker almost became that of a meeting minute taker.
20 When this was queried I was told that there was no 10:20
21 administrative staff to do this. It was inappropriate
22 for a social worker to be given this role as they are
23 required to actively participate in meetings,
24 particularly when discussing needs of patients who were
25 preparing to be discharged. 10:20
26
27 I'm confident that H92, H93, and H84 did their utmost
28 to promote the human rights of the patients and to
29 uphold their social work values. When reviewing the

1 records at Muckamore following the revelation of the
2 CCTV footage in 2017, I found records between 2012 and
3 2017 noting that meetings were held by staff at
4 Muckamore where a community social worker was not
5 invited and a follow up e-mail would be sent to them 10:21
6 from a senior manager asking why the social worker did
7 not attend.
8
9 In July 2016, I took post as Operations Manager. I was
10 responsible for community teams in the East and West 10:21
11 Belfast Trusts. I was also the social work lead for
12 the service. I worked closely with a colleague who was
13 a nurse responsible for the north and south teams. It
14 is standard professional practice for social workers to
15 ensure that there is to be an unbroken operational 10:21
16 chain of accountability from the social worker through
17 to the Executive Director of Social Work. The social
18 workers in Muckamore were operationally managed by
19 H507. This led to them sitting out on their own.
20 10:22
21 Following the uncovering of the abuse, H507 was removed
22 from post. A new collective leadership team was
23 appointed and this did not resolve the issues raised in
24 the "A Way to Go" and leadership reports.
25 10:22
26 The new senior management team had no experience in
27 learning disability and appeared not to understand the
28 complexities of how to support people with learning
29 disabilities and their families. It is my opinion that

1 they disregarded staff who had many years of experience
2 and training in this field.
3
4 I remember meeting with a senior team in and around
5 2018/2019 at Muckamore to discuss those patients who 10:22
6 had been subject to abuse. It was common practice to
7 describe mothers as having mental health difficulties
8 and fathers as being aggressive and it was my view that
9 their very real concerns were dismissed because of
10 this. 10:23
11
12 Plans around discharging patients can only be described
13 as chaotic. I recall a meeting with Muckamore staff to
14 discuss a patient being discharged back into the
15 community. In order to ensure the patient was cared 10:23
16 for, a plan would be prepared to include a care
17 provider.
18
19 At a meeting for a patient about to be discharged in
20 the following two weeks, and which I had to Chair, and, 10:23
21 where the care provider, the patient's mother and an
22 advocate for the patient were in attendance, a positive
23 behaviour nurse employed by the Trust said that the
24 care was not robust enough and that the previously
25 agreed staffing levels needed to be increased by 30%. 10:23
26 This placement had been two years in the planning and
27 it was not acceptable that this announcement should
28 have been made at this late stage. Major aspects of
29 his behaviours that were challenging were not shared

1 with the provider. This patient was discharged on
2 trial to supported living in 2019. He struggled and as
3 a result of his distress he caused injury to his
4 carers. Following assessment, it was agreed by the
5 community MDT that he should return to Muckamore for a 10:24
6 short period to allow the care staff to regroup.
7 Muckamore refused to admit him.
8
9 At a meeting to discuss this decision I was directed by
10 the service manager, H294, to change the patient's 10:24
11 legal status from detained patient to guardianship on
12 the instructions on the director. I do not believe
13 that the director did give this instruction. I am an
14 approved social worker under the MHO for 20 years and I
15 knew this could not be done, I therefore refused to do 10:24
16 this. I recall the manager pointing her finger at me
17 in front of junior staff and the provider. I felt
18 extremely disrespected, I followed up on this meeting
19 by e-mail to the Service Manager at Muckamore but
20 received no reply. 10:25
21
22 The placement broke down and as far as I am aware, the
23 patient remains at Muckamore to this day. I believe
24 that the placement could have been salvaged if
25 Muckamore had worked with the MDT. 10:25
26
27 P96, one of the service users involved in the
28 investigation, was admitted as a patient under the
29 Mental Health Order in April 2017. I was aware of

1 P96's case as the social worker was a part of one of my
2 teams. We had a good relationship with his parents. I
3 remember that we fought hard to get P96 home, but the
4 one thing missing from his plan was day care. The day
5 care manager in the community refused to allow him to 10:25
6 return to his previous day care. P96 remained as a
7 patient in Muckamore for longer than I believe he
8 needed to be. His father asked to see CCTV footage
9 around the date of the assault he had been informed
10 about in August 2017, and was told that the security 10:26
11 cameras did not work. I would wish to apologise to
12 P96's family that I could not do more to get him home.
13
14 Following the release of CCTV footage to the PSNI, I
15 was appointed a DAPO along with two others. My role 10:26
16 was to act as lead to ensure safeguarding of patients.
17 Along with my colleagues, we looked at and reviewed
18 CCTV footage released at Muckamore to identify any
19 incidents.
20 10:26
21 I felt that we were made very unwelcome at Muckamore
22 when attending to review the CCTV footage. We were
23 given the CCTV footage in a bizarre way. For example,
24 we were provided with footage from March 2017 and the
25 next recording would be from September 2017. There was 10:26
26 no continuity.
27
28 When reviewing the CCTV footage, we were told by
29 Muckamore that there were no incidents at night. One

1 of my colleagues found footage of abuse early in the
2 morning and decided to roll the camera back two hours.
3 She found that all the staff on the ward were sleeping.
4
5 After watching the CCTV footage I contacted the 10:27
6 families to tell them that their loved ones had been
7 abused on CCTV but I could not tell them exactly what
8 happened due to the PSNI investigation. Each time I
9 saw something I had to call the patient's family. I
10 had to call some families three or four times a week. 10:27
11 Each time I had to absorb their hurt and anger. I also
12 reported to the Trust. I did this for around seven
13 months before the Trust became aware that the
14 allegations of abuse were much bigger than originally
15 anticipated. 10:27
16
17 In and around late 2017/early 2018 the number of
18 patients in Muckamore was down to about 50 patients. I
19 was asked by the Trust to go to Muckamore to see why
20 the remaining patients had not been discharged. When I 10:28
21 asked to see patient assessment files to include
22 occupational therapist and social worker assessments,
23 there were no documents available. I found there was a
24 great sense that the remaining patients were too
25 difficult to discharge. I found that there was a great 10:28
26 resistance to set up a care plan to share with
27 providers so that the remaining patients could be
28 discharged.
29

1 I recall that there were investigations into the
2 treatment on the Ennis ward in and around 2019. I was
3 not directly involved but, for me, this was a key
4 moment that highlighted the divide between Muckamore
5 and community Trust social workers. 10:28
6
7 During the investigations Aine Morrison, Carmel
8 Drysdale and Collette Ireland, who are all very
9 experienced social workers, raised a lot of concerns.
10 It seems that many staff at Muckamore are related and I 10:29
11 understand that when staff raised concerns they were
12 moved to another ward and often felt ostracised."
13
14 CHAIRPERSON: Right, now before you are asked to
15 confirm that statement, we forgot to swear you in so 10:29
16 that's my fault in large part so I am going to ask that
17 you are sworn in now, apologies.
18
19 WITNESS A4 SWORN
20 10:29
21 CHAIRPERSON: Thank you, right Mr McEvoy, now we can
22 see if we can confirm the statement.
23 12 Q. MR. MCEVOY: A4, can you confirm that what I have just
24 read out then is your statement to the Inquiry?
25 A. It is. 10:29
26 13 Q. And you're content to adopt it as your evidence to the
27 Inquiry?
28 A. I am content to adopt it.
29 14 Q. There is one final paragraph and it appears at

1 paragraph -- there is page 10 which is a paragraph 32
2 and there you say:
3
4 "My sister is used to talking about her experiences at
5 Muckamore and provides training on the ASW course. She 10:30
6 has indicated she will be happy to speak to the Inquiry
7 about this but would require special measures. She
8 would not be able to speak to a large room of people."
9
10 That's just a further paragraph, I think that came in 10:30
11 -- okay.
12
13 Right, now that we have you sworn in A4, can I take you
14 back just to the outset of your description of your
15 role as a social worker. I think in any analysis you 10:30
16 have quite a bit of experience there, you began in 1995
17 as you tell us. In terms of the later development when
18 you became a DAPO and then your role as the Adult
19 Safeguarding Lead, you refer to a policy called the
20 Adult Prevention and Protection in Partnership Policy? 10:31
21 A. Yes.
22 15 Q. Top of page 5, so it's the end of paragraph 11, can you
23 tell us something about that policy and what it does
24 and how it operates?
25 A. That's the regional policy set out by the Department of 10:31
26 Health which outlines thresholds for investigations,
27 how investigations should be carried out and the roles
28 of the DAPO and the Investigating Officer. It was
29 preceded by previous policies which would have been

1 known perhaps as the Vulnerable Adults Policy really
2 from my knowledge.
3 16 Q. Slowly if you can?
4 A. I keep forgetting I speak very quickly. These were
5 preceded by vulnerable adult policies probably going 10:31
6 back to around 2000, but this is the latest and this
7 remains the current operational policy for adult
8 safeguarding, regardless of where it happens in
9 Northern Ireland.
10 17 Q. And when you say it is regional then, who would have 10:32
11 ownership of and authorship of it?
12 A. The Department of Health.
13 18 Q. Paragraph 12 then, go back to the commencement of your
14 work as a social worker in the community team in
15 Belfast. And you say that as part of your role it was 10:32
16 normal practice to attend Muckamore to meet patients.
17 When you say it was normal practice, how frequently?
18 A. I suppose, Chair, that would depend on how long the
19 person had been in and what their journey through it
20 was. Certainly when someone was admitted, either under 10:32
21 the Mental Health Order or on a voluntary basis,
22 although usually it would have been under the Mental
23 Health Order, there would have been a meeting set up
24 within maybe 7 or 14 days after admission and that was
25 to commence discharge planning. So that would have 10:33
26 looked at why the person had come into Muckamore, what
27 additional supports perhaps could have been afforded at
28 home to them and what their journey out might be,
29 whether it might be returning to their family home, to

1 their placement or to seek a new placement. For those
2 people who were there much longer term, there probably
3 was a period where we would have relied on the hospital
4 social workers to do a lot of the work, and then when
5 it came towards discharge the community social workers 10:33
6 would have been much more involved in terms of working
7 alongside our care management colleagues to find a
8 suitable placement to make sure the assessments were
9 right, to make sure the care plans were there.
10 19 Q. Slow down again. There is a lot of information there 10:33
11 and we want to make sure we get it all?
12 A. And also really to act as a conduit I suppose between
13 the hospital and families. Certainly families where
14 there is someone with a learning disability, there is a
15 very high level of input and should be a lot of 10:34
16 co-working with families to make sure that they are
17 content with any proposed placement. And then once the
18 person would be discharged from Muckamore it would be
19 back to the community teams to do the follow up. So we
20 would have gone I suppose, when somebody was admitted 10:34
21 there would have been a number of meetings and then you
22 might have been asked to come to review meetings. But
23 it also would have been normal practice, certainly from
24 my memory, prior to 2012, if I had been up to see one
25 patient, I might have popped in to another ward just to 10:34
26 see how someone else was. If there had been an
27 incident, you might have gone up to see them, it would
28 have been very normal practice maybe to see six or
29 seven people when you were up in an afternoon. And

1 most of those visits prior to 2012, I don't remember
2 there being a lot of booking appointments, you just
3 turned up to the ward.
4 20 Q. CHAIRPERSON: Could I just ask this, when you were
5 looking at resettlement and you started doing that very 10:35
6 soon after the patient had been admitted for many
7 patients, would the philosophy have been can we get
8 this patient home with support and then look at
9 alternative placements if you can't do that, or would
10 you just look at it, as it were, looking at any 10:35
11 placement that would work?
12 A. I think it would very much have depended on the
13 individual. So some families were very clear that they
14 wanted their loved one to return to live with them.
15 For some families it's never easy letting go of someone 10:35
16 with a learning disability. I think, as a family
17 member myself, you never quite feel somebody else is
18 going to look after them the way you do. So that kind
19 of planned moving on, which is certainly advocated in
20 Bamford. 10:36
21 21 Q. CHAIRPERSON: Yeah?
22 A. All of those previous policy documents talk about
23 planning ahead and doing that in a very planned way.
24 However, when someone is admitted to somewhere like
25 Muckamore, that can quite often be the point where a 10:36
26 family say we can't cope any longer or where we might
27 have been really starting the discussions around this
28 is probably not the best and we need to look at
29 alternatives. So it would have been very much

1 dependent on the individual service user and on their
2 families.
3 CHAIRPERSON: Okay, thank you.
4 22 Q. PROFESSOR MURPHY: Can I just ask something while we
5 are on this subject? Could you clarify for us how 10:36
6 social workers in the hospital were based, where they
7 were based and how many there were because you were
8 clearly coming in from the community to visit patients?
9 A. I suppose to go back prior to 2012, most of the wards
10 would have had their own social worker. They were 10:37
11 based on site in a separate building but they were on
12 site. And actually as time went on, the number
13 decreased until at the very end there would have been a
14 Band 7 senior social worker and two permanent social
15 workers. Now certainly in my time, I then brought in 10:37
16 an agency member of staff, particularly to focus on Six
17 Mile, the forensic unit, because the needs of those
18 patients is very particular. Prior to that, there was
19 the team leader prior to maybe 2014, not just too sure
20 on the dates, it's a long time ago, the senior social 10:37
21 worker would also have been the DAPO. My understanding
22 is that following Ennis a DAPO then was brought in for
23 the hospital and that DAPO really focused on patient on
24 patient incidents. And I know you've read Margaret
25 Flynn's report and she will talk about the vast amounts 10:38
26 of documentation there was around patient on patient
27 incident, as compared to any allegations against staff.
28 That DAPO did that. In terms of allegations against
29 staff, those were sent out to the Owning Trust, so if

1 it was a South Eastern Trust patient it was sent out to
2 the South Eastern Trust. What became very clear to me
3 when I took on more ownership of the social workers in
4 Muckamore was that actually that probably wasn't
5 helpful, because Trusts are very busy places and people 10:38
6 weren't necessarily joining up the dots and saying this
7 service user has named this member of staff, oh, that
8 service user has also named that, so that collation of
9 information wasn't what it should have been.
10 10:39
11 I think the other thing too is that by I suppose the
12 last 10 years the profile of the patients in Muckamore
13 were much more likely that they were to be more
14 severely disabled. They were more likely to be
15 autistic. They were more likely to have poor 10:39
16 communication skills. And many of them could not have
17 told you, they could not necessarily have named a
18 member of staff. It was also, it would have been very,
19 very easy to discredit a patient very easily. And
20 quite often because families were maybe seeing them 10:39
21 once a week, they were travelling from all over the
22 country, if there had been a bruise the person may not
23 have remembered.
24 23 Q. CHAIRPERSON: Can I just stop you because I think we've
25 gone offline a little bit, because the question was 10:39
26 could you clarify for us how social workers in the
27 hospital were based, and where they were based?
28 A. So towards the end then we had one social worker who
29 covered Six Mile, which was the low secure units. We

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1 had one social worker who covered the female ward. One
2 social worker who covered Cranfield, the two male
3 wards. And the long stay ward actually was not funded
4 for a social worker.
5 CHAIRPERSON: Right. 10:40
6 A. Which given they were the patients who were there the
7 longer.
8 24 Q. CHAIRPERSON: Were they based at the hospital?
9 A. They were all based at the hospital and had been very
10 long-term in the hospital. 10:40
11 CHAIRPERSON: Sorry to interrupt.
12 PROFESSOR MURPHY: Thank you.
13 25 Q. MR. MCEVOY: Picking up on that point maybe before we
14 leave it about ownership of an issue of staff on
15 patient abuse that you touched on there, that it would 10:40
16 remain with the owning Trust as you put it. When did
17 that practice become established from your
18 recollection?
19 A. I think that practice had always been there from the
20 first vulnerable adults policy came in. It changed 10:41
21 somewhere around 2014 when it kind of seemed to make
22 sense that the DAPO in the hospital would carry out the
23 investigations because they were there, they could do
24 it immediately and you weren't relying on people having
25 to clear their diaries to come up and interview and 10:41
26 they knew the patients maybe better than some of the
27 named workers in the community might have done.
28 26 Q. You have expressed a bit of concern to the Panel about
29 that practice and how dots might not get joined up.

1 Did you express that to anybody at the time or is that
2 a view you're coming to looking back on it?
3 A. I think it probably was once I took up my role in 2016,
4 having that kind of overall view of adult safeguarding,
5 that that's when it became more obvious that the 10:41
6 investigations maybe weren't just as thorough as they
7 would have been within a community team. I think the
8 community team, if we had been asked to go in and
9 investigate an independent service provider, we
10 probably did it more thoroughly than I think it 10:42
11 probably was done in Muckamore.
12 27 Q. You --
13 A. And I think that was probably to do with the volume of
14 patient on patient, just the huge numbers meant it was
15 actually very difficult to sort out what actually met a 10:42
16 threshold and what could have been dealt with via
17 alternative safeguarding responses or alternative plans
18 that could have been made.
19 28 Q. Okay, and you touched on it being easy to discredit an
20 allegation. How do you know that? 10:42
21 A. I suppose patients have now reported to us that they
22 did raise concerns. There certainly would always, very
23 very difficult for anybody with a learning disability
24 to tie things down to time or to dates.
25 29 Q. Yes? 10:43
26 A. So they might have said 'so and so hit me yesterday'
27 and people will have gone, well that person wasn't on
28 duty yesterday, but they might have been on duty the
29 day before, so very, very easy. Very difficult to get

1 witness statements from anybody else and just a whole
2 load of issues that kind of made it more difficult I
3 think for patients and then their families to raise
4 concerns.
5 30 Q. In the period prior to 2012, just going back to your 10:43
6 statement, you talk about positive experiences with the
7 doctors, you have identified them. Would it be right
8 to characterise the way things were done up until 2012
9 that we talked about a few moments ago in terms of your
10 interactions with Muckamore and the people running it, 10:44
11 i.e. the doctors, as being more collaborative in
12 nature?
13 A. Absolutely, absolutely. I forgot what her cipher was,
14 but yeah, I mean H41, who was the medical director, who
15 knew every patient that was there intimately and the 10:44
16 experiences. Very, I mean she would have been very
17 challenging to community staff about what are you
18 doing, but the experiences from families was that she
19 absolutely was on their side and a very clear vision
20 about what was needed for the patient. 10:44
21 31 Q. You have singled her out for particular praise, what
22 about the others?
23 A. The other, I think generally we found all of the
24 doctors that were there at that stage very easy to work
25 with, very open to listening to social work points of 10:45
26 view, I couldn't say there was anybody that was
27 particularly difficult with us at all.
28 32 Q. Then as you say at paragraph 14 then, a change comes in
29 your experience from around 2012?

1 A. Mm-hm.
2 33 Q. Can you give us a bit more detail on what it was
3 brought about the change?
4 A. I suppose it's quite hard to tie it down to exactly
5 what it was. I suppose thinking back it probably was 10:45
6 around the time of the Ennis investigation and, much as
7 I wasn't involved with it, we got some of the feedback
8 around what the issues were and yet there wasn't a
9 feeling that those were acted on. The appointment of
10 H507, her background was adult mental health and much 10:45
11 as on the outside it can look as if there are a lot of
12 similarities between mental health and learning
13 disability, they are very, very different services.
14 And actually to, I think to successfully lead a
15 service, you either need to have had a lot of 10:46
16 experience in it, and certainly in social work, I can't
17 speak so much about nursing, but certainly in social
18 work people come into learning disability as social
19 workers when they take up post and very few of them
20 ever move again, it's a very long-term commitment. So 10:46
21 people have a long commitment to it, they are there
22 because they want to do the best for their service
23 users. They understand the policies. They understand
24 the legislation and they understand the ethos of people
25 with a learning disability should be living in ordinary 10:46
26 homes in the community. It's not rocket science.
27
28 H507, as I say, came in from a mental health background
29 and I suppose, I couldn't put a time frame as to how

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1 soon it became apparent, but it was very much Muckamore
2 is a hospital, it is a hospital to treat people and a
3 lot of the personal effects of people started to
4 disappear, a lot of the kind of social activities.
5 34 Q. Yes? 10:47
6 A. Started to disappear.
7 35 Q. I want to ask you about that in a moment.
8 A. That's fine.
9 36 Q. Because it is important. But just before we do come to
10 that, you touched on the appointment of H507 as service 10:47
11 manager?
12 A. Yes.
13 37 Q. Up until that point you seem to have, if one reads your
14 statement perhaps correctly, certainly my reading of
15 it, is that you have an open and positive relationship 10:47
16 with the doctors that you've named, that you have
17 identified. There's a fairly collaborative, one could
18 almost say open door approach in terms of your work in
19 the hospital?
20 A. Yes. 10:48
21 38 Q. Is H507's appointment, is that a structural, does that
22 amount to a big, structural sort of change as to how
23 that relationship and that dynamic works?
24 A. I think it felt like that as the months and years went
25 on, it did feel that way. 10:48
26 39 Q. CHAIRPERSON: Can you just pause for a second? Can I
27 ask this, rather than focusing on the individual, there
28 was a policy change at the hospital?
29 A. I think it was a policy change but I think it was

1 driven by H507's background and lack of understanding
2 of how Muckamore operated. Again, you look at Bamford
3 and very clearly nobody should be living in a hospital.
4 But if you've got to live in a hospital because there
5 was no funding for alternative places, then it -- the 10:49
6 quality of life there should be as good as it can be.
7 And I kind of think up until that point it was a much
8 more positive experience for patients. I suppose
9 treatment of someone with a learning disability is not
10 just about their medication, it is about that overall 10:49
11 building of their self-confidence and giving them a
12 very good quality of life.
13 40 Q. MR. MCEVOY: I suppose if I maybe ask you, ask you the
14 question or ask you about the issue in a slightly
15 counter-factual way but you'll bear with me, I hope. 10:50
16 If H507 or somebody in that position had come from a
17 learning disability background, and I know I'm asking
18 you to speculate a little bit, how might that bear on
19 how things might have gone?
20 A. I think a lot of the kind of recommendations from 10:50
21 Bamford and learning from other reports would probably
22 have been embedded in a much better way. I mean I
23 would want to say I don't think it was -- given that I
24 was fairly junior still in the organisation, I don't
25 know what pressures were being put on H507 to change 10:50
26 things either.
27 CHAIRPERSON: You can only give your impression.
28 A. Exactly.
29 41 Q. CHAIRPERSON: Can I just ask this, how often were you

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1 visiting the hospital?
2 A. It would have depended on whether I had patients who
3 had been admitted. So there could have been phases
4 where you could have been there very, very regularly.
5 42 Q. CHAIRPERSON: Which would mean what, once a week or 10:51
6 more than that?
7 A. Once a week or once a fortnight. Obviously as I took
8 my role up as team leader I wouldn't have been quite so
9 often, but I would have been hearing from members of my
10 team about when they had been up for visits as well. 10:51
11 43 Q. PROFESSOR MURPHY: Can I also ask, what the doctors'
12 attitude was to this change, because the kind of thing
13 you're describing where there's a sudden emphasis on it
14 being a hospital and not kind of ordinary life and you
15 shouldn't have possessions in your room et cetera, et 10:51
16 cetera, that's normally seen as a kind of
17 medicalisation of what's happening. So I'm just
18 wondering, you know, were the doctors in favour of this
19 change did you think?
20 A. I'm not sure that I ever had any of those kind of 10:52
21 conversations. I suppose what we did see in the years
22 after 2012 was an increasing emphasis on when we needed
23 someone admitted under the Mental Health Order, that
24 they should have a mental health diagnosis, so a
25 depressive illness or a bipolar episode or whatever, 10:52
26 and the Mental Health Order obviously allows for
27 admission of people, because, you know, the criteria
28 are severe mental handicap in terms of the legislation
29 and serious risk of physical harm to self or others.

1 So when someone's behaviour became very challenging, it
2 may not have been due to a change in their mental
3 health, it may have been something else, and we lost
4 the ability to get people safely admitted for periods
5 of assessment, a multidisciplinary assessment. So not 10:53
6 just about medication, but about speech and language
7 therapy assessments, around communication, OT
8 assessments, social work assessments, behavioural nurse
9 assessments, we seemed to lose that because there was a
10 greater emphasis on Muckamore becoming somewhere to 10:53
11 treat people with a learning disability who had a
12 diagnosis of a mental health condition, meeting the
13 criteria then.
14 44 Q. PROFESSOR MURPHY: Painful as that may have been, do
15 you think that was an attempt to move the service from 10:53
16 relying so much on a hospital to provide those kinds of
17 assessments, because arguably they could surely occur
18 out in the community?
19 A. I suppose when I look at the total number of people
20 with a learning disability that we had in Belfast, so 10:53
21 we had over 1,700 of them, lots of those people had
22 behaviours which were challenging and changes in their
23 circumstances and changes in their life circumstances
24 and we managed the vast majority of those when we were
25 seeking admissions. Those were for the people that we 10:54
26 had exhausted everything within the community, whether
27 that was our behaviour support team, whether it was
28 enhanced packages. And certainly in the case of P96,
29 you know, the work that was done to prevent that

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1 admission was phenomenal. The senior practitioner who
2 worked on that case was phenomenal in what she did.
3 But there clearly were occasions when somebody needed a
4 more intense day-to-day assessment by all those
5 professions. 10:54
6 45 Q. PROFESSOR MURPHY: So was it your feeling that
7 admitting people to Muckamore at around that time,
8 2012, was getting much more difficult?
9 A. Yep, absolutely.
10 PROFESSOR MURPHY: Thank you. 10:55
11 46 Q. MR. MCEVOY: And Professor Murphy asked you about
12 whether you had any sense of what the doctors views on
13 that were, nothing?
14 A. Nothing, no.
15 47 Q. From your experience? 10:55
16 A. From my experience, yes.
17 48 Q. You tell us in paragraph 14 that you found that, just
18 picking up on the point that you made about how it was
19 really only a tiny percentage of service users found
20 their way to Muckamore, you say: 10:55
21
22 "I found that the nurses became more professional and
23 lacked warmth."
24
25 Can you tell us a bit more about what you mean by that? 10:55
26 A. I think what I started to really see then was less of,
27 less empathy. Sorry -- I suppose what I started to
28 see was a greater emphasis on completing documentation,
29 on completing nursing assessments and care plans and

1 things like that. And I think what families were
2 reporting to us was that nurses were less likely to
3 listen to them. I think that was reflected in one of
4 the later paragraphs where I certainly attended a
5 number of meetings where there were comments made on 10:56
6 nearly every patient, that mother has mental health
7 issues, that father is aggressive. So that
8 understanding of what it was like for parents to try
9 and support very challenging people at home seems to
10 have gone. 10:56
11 49 Q. Okay and so we understand a bit more about what you
12 mean by that, when you talk about the nurses becoming
13 more professional and lacking warmth, are you talking
14 about the same individuals or something else?
15 A. Certainly it would have been across the admission 10:56
16 wards, which were Cranfield and then Donegore, Ardmore,
17 whichever, Killead, it changed names a few times. The
18 nurses in Erne, in the long stay ward certainly
19 continued, and those were patients that were there for
20 a very long time. There was more of a feeling that 10:57
21 while, yes, it was a hospital, but they did recognise
22 this was people's homes. But having said that, you
23 know, some of the conditions in Erne in terms of the
24 ward manager raising concerns about bedding not being
25 replaced, it was well, the hospital is downsizing and 10:57
26 we're changing and there's no money for that, I don't
27 know where that was driven from, that was above my pay
28 grade probably.
29 50 Q. But this sort of change in approach?

1 A. Yeah, clinical I think is probably the word, it became
2 a much more clinical response.
3 51 Q. As opposed to?
4 A. To knowing the person holistically, it was treat their
5 mental illness, do the assessments and then keep them 10:58
6 well and safe until --
7 52 Q. You talked about Erne in a slightly different context
8 there, are you caveating this impression, it wasn't
9 hospital-wide necessarily?
10 A. It probably was more the admissions wards. 10:58
11 53 Q. Okay. And towards the end of the paragraphs one of the
12 strings that's striking that you talk about is how
13 patients' bedrooms where their personal possessions
14 were stripped and the environment became more sterile.
15 Again, was that Muckamore-wide, was that confined to 10:58
16 certain wards?
17 A. No my understanding is that it was Muckamore-wide and I
18 completely understand, you know, IPC Regulations and
19 things like that. But for some of them, you know, you
20 look at P96, he had never been away from his parents' 10:58
21 care other than for short periods of respite and to
22 suddenly go into somewhere where his favourite toys and
23 objects and photographs weren't there, it must have
24 added to his distress when he clearly didn't understand
25 where he was and why he was there. 10:59
26 54 Q. PROFESSOR MURPHY: So did you raise that issue with the
27 ward managers, because presumably they were instructing
28 their staff to remove people's possessions?
29 A. I didn't and, again, it's probably something that now

1 in hindsight I regret that we didn't push back on a bit
2 more.
3 55 Q. MR. MCEVOY: Had you pushed back would you have been
4 listened to?
5 A. I don't think so. 10:59
6 56 Q. Did any other professionals, other than the social work
7 team, express any concern or issue about this change,
8 other than the doctors, we have touched on the doctors?
9 A. I am not aware.
10 57 Q. In terms of your, without naming names, in terms of 11:00
11 your colleagues, your social work colleagues, was this
12 a concern that was shared among the team?
13 A. There certainly would have, amongst the social workers
14 in the community kind of comments around well we're now
15 being asked to see people in visitors' rooms which were 11:00
16 outside of the ward environment. That became much more
17 noticeable. I'm not sure if we asked for an
18 explanation. I am not sure if we were given one. I
19 just can't remember to be honest.
20 58 Q. Do you know whether the stripping of the bedrooms 11:00
21 policy or directive, whatever you might want to call
22 it, whether that was explained to relatives and indeed
23 patients?
24 A. I don't know, no.
25 59 Q. And this then coincided with paragraph 15 then, you say 11:00
26 that when you were attending Muckamore you were no
27 longer allowed access to the open ward, you were
28 brought into a room to meet with patients?
29 A. Mm-hm.

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1 60 Q. You weren't aware of any seclusion rooms at this time?
2 A. No, again, hindsight is a great thing, I never asked to
3 see the seclusion room. I, up until 2017 when the
4 investigation started, I don't think I ever was in the
5 Intensive Care Unit, I don't think I was ever in PICU 11:01
6 at all.
7 61 Q. Were you aware of it's existence?
8 A. Yes, I would have known we would have had patients in
9 there, I don't remember, I just have no memory. I
10 definitely was never there and I certainly never saw 11:01
11 the seclusion room. I know P96's mother expressed her
12 shock at it and I have to say when I saw it, I was
13 appalled at what it looked like as well.
14 62 Q. When you were no longer allowed access to open ward,
15 how was that communicated to you? 11:02
16 A. You just would have, when you went --
17 63 Q. You personally, how was it conveyed to you personally?
18 A. The service user would just have been brought out to a
19 visitors room and you met with them there.
20 64 Q. Okay, just so we understand this correctly, you would 11:02
21 have been able presumably on a Wednesday afternoon of a
22 given week, been able to go up and go onto the ward and
23 then presumably then come around the next Wednesday
24 afternoon of the following week, something had changed?
25 A. Yeah, mm-hm. 11:02
26 65 Q. DR. MAXWELL: Can I just ask when you were asked to see
27 the service user in the visitors room, did you actually
28 say 'can I go on to the ward' or did you just see them
29 in the visitors room?

1 A. I suppose on a few occasions it might have been that
2 the ward was very you unsettled and it might not have
3 been safe for me to go onto the ward I might have been
4 told. But it probably became custom and practice and
5 we stopped asking. 11:03
6 66 Q. DR. MAXWELL: So when you asked to see the patient in
7 the visitors room, did you say 'no, I'd prefer to see
8 them on the ward' and then be told you couldn't?
9 A. Probably not, no, probably --
10 67 Q. DR. MAXWELL: So you weren't actually prevented from 11:03
11 going on wards, you were --
12 A. Discouraged probably.
13 68 Q. You were expected to see them in the visitors room
14 rather than actively told no, you can't go on the ward?
15 A. On occasions would you have been told the ward is too 11:03
16 disruptive for you to go on to.
17 69 Q. MR. MCEVOY: Just picking up from that then, you were
18 discouraged as opposed to prohibited?
19 A. Prohibited, yes.
20 70 Q. Did you give up trying? 11:03
21 A. I probably did, yeah.
22 71 Q. Okay. You then have described in your statement about
23 how the social work team at Muckamore was reduced to
24 two people when previously there had been a social
25 worker dedicated to each ward. How did that reduction 11:04
26 in staff come about, and I suppose the follow on from
27 that is were you involved in discussions that were
28 leading to that decision?
29 A. I suppose for much of this I was a social worker myself

1 so I wasn't in a position of any kind of management.
2 Certainly, my memory is that as staff retired I know
3 certainly two, one staff retired and wasn't replaced
4 and the previous senior social worker retired and then
5 one of the social workers got that post and he wasn't 11:04
6 then replaced within the team, so it came down to two
7 social workers and then the DAPO added in, who also
8 covered Six Mile ward, which was probably the ward that
9 there were a lot of concerns about by the nature of the
10 patients there. So I kind of, I suppose when I did 11:04
11 take up managing them in 2017 or '18, there did feel as
12 if that was a conflict of interest so we then brought
13 in an agency member of staff in to cover Six Mile as
14 well.
15 72 Q. DR. MAXWELL: Can I just ask, how did this relate to 11:05
16 the reduction in the number of patients, because we
17 heard there was quite a reduction in the number of
18 patients over time?
19 A. There certainly was a reduction, however with the
20 reduction came an increased complexity of the needs of 11:05
21 those patients. So the whole kind of -- I still would
22 have thought each ward should have had that and
23 certainly in the hospital that I cover now, we do have
24 at least one social worker for each ward with similar
25 numbers, you know. 11:05
26 73 Q. DR. MAXWELL: Is there any guidance on how you
27 calculate how many social workers you need for a case
28 load?
29 A. No, there's nothing in terms of -- and even within the

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1 community settings, there is no guidance on what a
2 social work case load would look like.
3 74 Q. DR. MAXWELL: You said that you recruited an agency, so
4 presumably there was still funding because you wouldn't
5 have been able to do that if you didn't have the 11:06
6 funding for that post, so there was no reduction in the
7 funding?
8 A. I don't know because, again, the funding sat within the
9 Muckamore management and I wasn't Muckamore management
10 but certainly, yes, the funding was found. 11:06
11 CHAIRPERSON: We've been going about an hour, so I
12 thought we would take a short break, you have got a bit
13 to go, haven't you?
14 MR. MCEVOY: Yes.
15 CHAIRPERSON: So we'll take a 15 minute break, you'll 11:06
16 be looked after, you can go out through that door with
17 Jaclyn. I will just let that happen before anybody
18 gets up. Okay, thank you very much, 15 minutes.
19
20 THE HEARING ADJOURNED FOR A SHORT PERIOD 11:08
21
22 THE HEARING RESUMED AS FOLLOWS:
23
24 CHAIRPERSON: Thank you. Okay. Welcome back, have you
25 had a break and a cup of tea or something? 11:28
26 WITNESS: I did, thank you.
27 75 Q. MR. MCEVOY: Thank you Chair, thank you Panel. So, A4,
28 before our break I was asking you about the reduction,
29 the decision to reduce the social work cohort in

1 Muckamore. Moving just to what you say in that
2 paragraph about what that meant as well for the role of
3 the job done by social workers at Muckamore, and
4 specifically around the issue of ward meetings. You
5 told us that it had become reduced to that, the role 11:29
6 had become that almost of a meeting minute taker?
7 A. Mm-hm.
8 76 Q. Was that your first hand experience?
9 A. It absolutely was, Chair, that the social worker, there
10 was no admin staff to take minutes and it became the 11:29
11 role of the social worker to take the minutes and
12 taking minutes and participating in a meeting
13 meaningfully is very, very difficult.
14 77 Q. So when you're describing one of these ward meetings,
15 the Panel members will know, but for those of us maybe 11:30
16 it is hard to appreciate it, what sort of roles, what
17 sort of specialisms would have been represented at
18 those ward meetings?
19 A. So all specialisms should have been at those meetings.
20 The psychiatrist, consultant psychiatrist or their 11:30
21 registrar should have been at the meetings. Social
22 work, nursing, obviously, and then other professions,
23 if it had been necessary for them to be there, so our
24 occupation therapists, speech and language therapists,
25 behaviour specialists, psychologists, forensic 11:30
26 psychologists, depending on the nature of the meeting.
27 But the core participants should always have been the
28 doctor in charge of the ward or their rep, social work
29 and nursing. That would have been the minimum.

1 78 Q. How did it fall to the social worker to pick up the job
2 of making a minute?
3 A. I don't know, don't know.
4 79 Q. Okay. Moving on then to paragraph 18 and you're
5 stepping into the role of Operations Manager in July 11:31
6 '16. You took a responsibility for community teams in
7 the East and West Belfast Trusts and you were the
8 Social Work Lead for the service. You then describe
9 how it is standard professional practice for social
10 workers to ensure that there is to be what you describe 11:31
11 as "an unbroken operational chain of accountability
12 from the social worker through to the Executive
13 Director of social work." And then you say "the social
14 workers in Muckamore were operationally managed by
15 H507, not a social worker." 11:31
16 A. Mm-hm.
17 80 Q. "This led to them sitting out on their own". So are
18 you telling us then that that chain of accountability
19 was broken?
20 A. I suppose, looking back on my statement now, it's more 11:31
21 that there should be a professional unbroken chain from
22 your Band 5, 6 social worker right through to the
23 Executive Director of Social Work. Operationally
24 people might be managed by other professions but there
25 should always be a professional supervisor. I suppose 11:32
26 in terms of them sitting out on their own, when we
27 would have had social work forums in community the
28 hospital social workers had not previously been invited
29 to attend.

1 81 Q. What did the forum do?
2 A. Forums would be all of our Band 6, Band 7, Band 8
3 social work qualified staff would be brought together
4 on at east a quarterly basis and we would look at
5 perhaps a piece of research, a case study. 11:32
6 82 Q. When you say all brought together, where from?
7 A. Everywhere, so I would have been responsible for the
8 learning disability social workers.
9 83 Q. Are you talking about the Trust?
10 A. Yes, the Belfast Trust, we would have tried on a 11:33
11 quarterly basis to bring everyone together with maybe a
12 different theme. So somebody might have looked at
13 homelessness, somebody might have looked at a piece of
14 research. It is about constantly developing the social
15 work cohort professionally and the hospital social 11:33
16 workers were not part of that.
17 84 Q. DR. MAXWELL: Can I just ask, though, this is true for
18 all the professions, so none of the nurses had a direct
19 line of command to the Director of Nursing, the
20 Executive Director of Nursing. This is quite common in 11:33
21 most hospitals were there is a directorate system, the
22 line management usually go through a general manager.
23 This is an issue probably for all the professions, not
24 just one for social work?
25 A. And I think probably the difference here was that the 11:34
26 professional line wasn't always as clear through to the
27 Exec Director of Social Work as perhaps it should have
28 been.
29 85 Q. DR. MAXWELL: That's maybe a conversation we need to

1 take up with Executive Director of Social Work about
2 why and what arrangements they had in place for
3 professional leadership?
4 A. At that stage, yeah.
5 86 Q. MR. MCEVOY: Obviously you've told the Inquiry about it 11:34
6 in your statement today and in your answers to Dr.
7 Maxwell. Prior to today at the Inquiry have you raised
8 that as an issue?
9 A. I suppose we, in terms of the professional, we did
10 rectify that, we made sure that the social work staff 11:34
11 who were based in Muckamore were invited along and in
12 fact --
13 87 Q. To the forum?
14 A. To the forums and to other relevant -- so there would
15 have been DAPO forums for those who were ASWs, there 11:34
16 were ASW forums as well. So there was a lot of
17 emphasis put on making sure those staff were all
18 actively encouraged to at least attend the forums so
19 they were part of the learning disability services
20 rather than just Muckamore social workers. 11:35
21 88 Q. And how was that rectified?
22 A. We basically, we set up the meetings, we sent invites,
23 we kept attendance lists and then we queried as to why
24 they weren't attending.
25 89 Q. So you took it up yourself? 11:35
26 A. I did take it up, yeah, I did take it up.
27 90 Q. Okay. Moving then to paragraph 19, you say that:
28 "Following the uncovering of the abuse H507 was removed
29 from post". Are you wanting the Inquiry to understand

1 that the two facts are linked in some way?
2 CHAIRPERSON: I don't think the witness can comment on
3 that.
4 A. No, no.
5 91 Q. MR. MCEVOY: You then say: "A new collective 11:36
6 leadership team was appointed and this did not resolve
7 the issues raised in the "A Way to Go" and leadership
8 reports". What issues are you referring to there?
9 A. I know some of my colleagues will be in a better
10 position to comment than me in terms of the adult 11:36
11 safeguarding, particularly those issues. So some of
12 the issues that Margaret Flynn raised in terms of what
13 efforts were being made to get community placements for
14 those people who had been there for a very long time
15 and just the overall management of the hospital. Now, 11:36
16 I would also want to say that obviously following the
17 investigation starting, that things were in disarray
18 and I absolutely recognise that. We had large numbers
19 of staff who were no longer able to work and that made
20 managing the staff in the hospital very, it made it 11:36
21 very, very difficult for those managers who came in.
22 But again, unfortunately I think the managers who were
23 appointed were not from a learning disability
24 background so their knowledge of policies and
25 legislation was not what it should have been. And I 11:37
26 suppose my sense of it is that their willingness to
27 listen to those of us who had the experience was
28 limited. I think they became very focused on keeping
29 the hospital running on a day-to-day basis, which

1 absolutely needed to be done. But in terms of
2 improving things and moving things forward, they also
3 needed to listen to those of us who had the experience.
4 92 Q. CHAIRPERSON: Can I just ask what you mean by the
5 management team, again without naming names? 11:37
6 A. So the divisional, collective leadership team would
7 have been the medical director, the co-director for the
8 hospital and divisional social worker. I'm trying to
9 think if there was anybody else, but certainly those
10 three would have made the collective leadership team 11:38
11 up.
12 CHAIRPERSON: Right.
13 A. And I would have to say although the divisional social
14 worker was not from a learning disability background,
15 she was very keen to learn from her social work staff, 11:38
16 very keen to understand.
17 93 Q. MR. MCEVOY: Okay, in this paragraph, and a little bit
18 earlier in your evidence you talked about what is
19 described in your statement as a common practice of
20 describing mothers has having mental health 11:38
21 difficulties and fathers as being aggressive?
22 A. Yes, mm-hm.
23 94 Q. What do you mean by it being common practice?
24 A. It would have been regularly said at meetings around
25 the families of, particularly the patients who had been 11:38
26 there for a longer period of time, that when families
27 were raising concerns, you know obviously for anyone,
28 and given that many of these families had already been
29 told their loved ones had been subject to abuse, they

1 were very distressed, very upset and quite often that
2 can come across as anger. I couldn't tell you how many
3 meetings I would have heard mothers being described as
4 'well that mother has mental health difficulties' and
5 fathers as being aggressive. And that was particularly 11:39
6 for me noted in P96's family and in another family that
7 I referred to, a very difficult meeting. I actually
8 sat at one meeting, it stands out very, very clearly in
9 my mind where this was said and as a carer of someone
10 with a learning disability, I found this very upsetting 11:39
11 and actually verbalised that very clearly that, unless
12 you have cared for someone with a learning disability
13 who has had to go into a hospital for any reason, it's
14 very difficult to actually understand the impact of
15 that. And a senior nurse at the meeting patted me on 11:40
16 the back and said 'well I'm sure you're not difficult`
17 I thought well actually there are times in my life
18 where staff dealing with my sister would have said I
19 was difficult but I am there to advocate for her and
20 I'm there to ensure she gets the best treatment. So 11:40
21 that characterisation I think undermined the very real
22 concerns that those families were raising.
23 95 Q. CHAIRPERSON: Was that characterisation in your view
24 being used in order to dismiss and minimise those
25 concerns being raised? 11:40
26 A. Absolutely, absolutely was, yes.
27 CHAIRPERSON: Just take a moment.
28 A. It's okay.
29 CHAIRPERSON: Are you all right?

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1 A. Yeah, thank you.
2 96 Q. MR. MCEVOY: Were there, again without naming names or
3 identifying patients or indeed their loved ones, were
4 there ever any instances where that type of description
5 might have been warranted and justified in the 11:41
6 circumstances of the meeting?
7 A. I think that characterisation isn't helpful to many of
8 these parents who have cared for very complex
9 individuals, very complex children for very many years.
10 I would be very surprised if very many of them didn't 11:41
11 have some mental health issues. Their lives are not
12 what they thought it was going to be when their baby
13 was born and the impact, the lack of community services
14 to support them and the lack of resources to allow them
15 to plan in a positive manner. But particularly, as I 11:41
16 say, P96, you know, having been involved in his
17 admission and the stress on his family to actually
18 allow him to be admitted, so, yes, I am absolutely
19 confident many of those parents do have some mental
20 health difficulties. The fathers being aggressive, I 11:42
21 think that was just fathers being frustrated and being
22 very assertive in their challenging of what was
23 happening in the hospital.
24 97 Q. In the following paragraph then you talked about your
25 experience of discharge plans and issues that you 11:42
26 experienced and are familiar with. The word you use is
27 "chaotic"?
28 A. Chaotic.
29 98 Q. To describe that. Why do you choose that word?

1 A. I suppose my experience of when we would have been
2 organising placements for people in the community is
3 that there is a very set pattern to doing things. So
4 you would normally expect a GP assessment, you would
5 expect a social work assessment, a nursing assessment, 11:43
6 if it was relevant from a learning disability nurse,
7 and then any other relevant OT, speech and language
8 therapy, behaviour. So you would expect to have all
9 that information gathered up and passed to a care
10 manager who would have looked for the placement. 11:43
11 Families would have been worked very, very closely with
12 and service users where it was appropriate as well to
13 draw up that care plan which should have been the way
14 that placements could have said yes, that's someone we
15 can support. The placement itself would then develop 11:43
16 its own care plan based on ours. So it was a very, I'm
17 not saying it was a straightforward process, but it was
18 a process that's well embedded in under care management
19 policies I think from around 2010. What we found was
20 when we went to Muckamore that it was nearly like 11:44
21 identify the placement and then we'll do the
22 assessments. So in this particular case that I've
23 talked about, it had been two years in planning by the
24 care manager based in the community, turned up at a
25 meeting to look at a number of issues, a very, very big 11:44
26 meeting, and there was no-one from the hospital
27 prepared to Chair the meeting. So I ended up chairing
28 a meeting that wasn't my meeting and suddenly behaviour
29 nurse said well no, instead of him needing two to one

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1 staffing, we think he needs three to one, well where's
2 your assessment, what's changed. And for the family
3 member that was there, that must have been so
4 distressing for her to think we are weeks off. It had
5 taken us two years to get the independent service 11:44
6 provider to recruit sufficient staff to meet his needs
7 and then suddenly it was well actually, you need to
8 increasing your staffing team by 30% within a few
9 weeks.
10 99 Q. PROFESSOR MURPHY: Given they were in hospital and some 11:45
11 of them had been in hospital for a very long time, how
12 come those kind of multidisciplinary assessments were
13 not already in place?
14 A. That's exactly the question that we raised. I know I
15 said in my statement a colleague a nursing colleague of 11:45
16 mine and I actually did a walk round all the wards and
17 said let me see your nursing assessment, social work
18 assessment, no, no, there is no separate social work
19 assessment. Well why not, because that's different
20 from a nursing assessment. Those weren't there. And 11:45
21 what we were being told is once a placement is
22 identified then we do our assessments. Now that's
23 counter intuitive but it is also absolutely the
24 opposite to the way it would have been within
25 community. You start with your assessment, you 11:45
26 approach the providers and they say we can meet this
27 person's needs. In terms of this particular patient,
28 he had very well documented behaviours and very well
29 documented -- those were not shared with the provider.

1 100 Q. PROFESSOR MURPHY: So the case manager is looking for
2 the placement, is that right?
3 A. Mm-hm.
4 101 Q. DR. MAXWELL: So who is the case manager?
5 A. It would have been one of our care managers. 11:46
6 102 Q. DR. MAXWELL: Tell me about care managers, where do
7 they sit, what is their background?
8 A. They could have a variety of backgrounds. They would
9 either have been a qualified social worker or a nurse,
10 probably could have been an AHP, but I don't think we 11:46
11 had any, and they sat in a separate team from the
12 community teams. I'm not entirely, I just cannot
13 remember now what the --
14 103 Q. DR. MAXWELL: They didn't, it wasn't ward staff doing
15 it? 11:46
16 A. No, it wasn't ward staff.
17 104 Q. DR. MAXWELL: It was a separate team who presumably
18 could and should have asked for the social work
19 assessments?
20 A. Yes, mm-hm. 11:46
21 105 Q. DR. MAXWELL: I am wondering why you think the hospital
22 would have the social work assessment?
23 A. We would have expected the social worker in the
24 hospital to have completed a social work assessment at
25 the point of someone being admitted. 11:47
26 106 Q. DR. MAXWELL: Are you saying that those hospital social
27 worker's notes would have been in the main patient
28 notes or would there have been separate social work
29 notes?

1 A. They were in the main patient notes.
2 107 Q. PROFESSOR MURPHY: This kind of back to front way of
3 doing placement planning where you find the placement
4 and then you try and fit into -- do you think that
5 arose because there was suddenly such a lot of pressure 11:47
6 to discharge people?
7 A. I don't know. I don't know.
8 108 Q. DR. MAXWELL: We have heard other people say that
9 actually there aren't as many placements available as
10 needed and that, you know, pragmatically maybe you had 11:47
11 to start from a point of well, what's available and
12 does it meet the patient's needs. Do you think that's
13 a potential --
14 A. I don't know, all I can say that's contrary to the care
15 management policy which I think is 2010. 11:48
16 109 Q. DR. MAXWELL: I understand it's not ideal but would you
17 accept the view we have heard before that actually, it
18 is difficult to find placements for certain patients,
19 that the providers just aren't out there providing the
20 level of care that ideally you would build if you 11:48
21 started with your patient's needs assessment and built
22 it around them?
23 A. I would absolutely accept there aren't enough providers
24 within Northern Ireland and specialist providers who
25 can provide the high level care that many of the 11:48
26 remaining patients need. However, I think if you don't
27 start out with clear assessments, and given that for
28 many of these patients we were working with independent
29 service providers to develop that, you can't really

1 develop a system, you can't develop a service if you
2 don't know what you're developing it to. So to
3 actually develop the service and say well, we will go
4 in and find who fits that, to me doesn't make sense but
5 maybe that's just me as a social worker. 11:49
6 110 Q. CHAIRPERSON: Can I just ask since we're on a roll as
7 it were from the Panel questions, this meeting that you
8 have just described where the positive behaviour nurse
9 effectively turned up and said no, this patient needs
10 more support, which would presumably mean that 11:49
11 placement wouldn't have worked, what was the case
12 manager doing? Because the case manager presumably
13 would have been at the meeting?
14 A. I actually just don't remember. I just remember me
15 having to Chair it and perhaps if the care management 11:49
16 comes forward then they could speak to that. I just
17 remember the look on the patient's mother's face when
18 it was we've worked so hard to get here.
19 111 Q. CHAIRPERSON: I understand that, your objection as it
20 were was that this came in as a late? 11:50
21 A. Late, mm-hm.
22 112 Q. CHAIRPERSON: If it was right though it was right,
23 whether it was late or not?
24 A. There was nothing to evidence that there had been a
25 change from the two to one staffing to the three to one 11:50
26 and that's what I was asking, where is your
27 reassessment, where is your evidence and they couldn't
28 produce it.
29 CHAIRPERSON: Right.

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1 A. It was just we think.
2 113 Q. MR. MCEVOY: So at this meeting then, number one, it's
3 a surprise effectively that is sprung on the relative's
4 family, and number two, not only is it a surprise,
5 there is no basis for it, no explanation for it? 11:50
6 A. Yes.
7 114 Q. DR. MAXWELL: Is that actually correct, would the
8 behavioural nurse specialist not be expected to use
9 professional judgment in the same way that a social
10 worker would? 11:50
11 A. But I would still have expected to have seen a written,
12 something written about why that had changed from a
13 meeting two or three weeks before, because in the point
14 coming up to discharge there is very frequent meetings.
15 I would have expected that to have been raised and not 11:51
16 raised there, I would have expected someone to have
17 raised that with the care management team who were
18 sourcing the placement, not to suddenly say in front of
19 a room with the provider and the family there.
20 115 Q. DR. MAXWELL: The care manager in the meeting said this 11:51
21 hasn't been raised before, did they?
22 A. I actually can't remember whether the care manager was
23 there, I just remember my experience of it.
24 116 Q. PROFESSOR MURPHY: Do you think there was financial
25 pressure of some kind being applied in that obviously a 11:51
26 placement could be much more expensive if you need
27 three to one than if you need two to one?
28 A. I don't remember finance actually being an issue in it.
29 Albeit that we know there is not enough finance about

1 to meet all of these needs. But I don't remember that
2 being used as a reason for not -- I suppose at the end
3 of the day any assessment is a legal document so, it
4 would be very hard to change that. I don't think
5 anybody came under pressure. Maybe other people had 11:52
6 other experiences, but certainly I don't remember
7 coming under any pressure to change any of my
8 assessments over the years.
9 PROFESSOR MURPHY: Okay, thank you.
10 117 Q. MR. MCEVOY: We know from your statement then after 11:52
11 assessment, following this and following assessment it
12 was agreed by the Community Multidisciplinary Team that
13 he should return to Muckamore for a short period to
14 allow the care staff to regroup?
15 A. Yeah. 11:52
16 118 Q. That re-admission was refused, you tell us, by
17 Muckamore?
18 A. Yes.
19 119 Q. Can you recall whether there was an explanation for
20 that refusal? 11:52
21 A. I think the understanding was that if he was
22 re-admitted and he was subject, he was a detained
23 patient under the Mental Health Order so he still
24 remained Muckamore's responsibility, there was a sense
25 that if he was returned to Muckamore that the provider 11:53
26 may withdraw the placement. I don't remember at the
27 meetings that I was at that the provider indicated that
28 that was the case. They just felt that they needed
29 more time to let staff settle, regroup and try again.

1 My memory of it is that it wasn't an issue with the
2 provider at all.
3 120 Q. Okay?
4 121 Q. DR. MAXWELL: Was it possibly that the behavioural
5 nurse specialist had actually been correct in her 11:53
6 assessment and there weren't enough support staff for
7 this patient?
8 A. No, I actually don't think it was. I think it was more
9 that, again, when you see behaviours written down it is
10 very different and people can tell you in writing all 11:53
11 the triggers but until you actually see it and until
12 you get to know the person very well. There was
13 additional support put in from Muckamore, they did an
14 awful lot of outreach, but I suppose the community
15 teams, our feeling was that if we could have had a 11:54
16 short break and tweaked things that perhaps needed
17 tweaked then he could have been discharged again.
18 122 Q. MR. MCEVOY: In the next paragraph then you reference a
19 meeting to discuss that decision and you tell us that
20 you were directed by the service manager to change the 11:54
21 patient's legal status from that of a detained patient
22 to guardianship. You said that you were told by that
23 service manager to do so on the instructions of the
24 director?
25 A. Mm-hm. 11:54
26 123 Q. And you don't believe that the director gave that
27 instruction?
28 A. No, I don't believe so.
29 124 Q. And can you tell us why you have that doubt?

1 A. The director was a social worker and I would have had
2 very good relationships with her, if she had wanted me
3 to do something she would have contacted me directly
4 and advised me and would have discussed with me why it
5 could or could not have happened. 11:55
6 125 Q. Okay, did you take it up with her?
7 A. I sent an e-mail to several members of senior staff
8 just expressing my concern.
9 126 Q. Was there a response?
10 A. No, there was no response. 11:55
11 127 Q. CHAIRPERSON: What difference would that have made to
12 change the patient's status from detained to
13 guardianship?
14 A. I suppose while he was detained he could have been
15 recalled to Muckamore. He was out on what we call 11:55
16 Article 15 leave so he could have been recalled to
17 Muckamore. Once he was under guardianship then he
18 effectively was discharged from the hospital, so to get
19 him re-admitted we would have had to have gone through
20 a whole assessment process with him again. 11:56
21 128 Q. CHAIRPERSON: So it would have been harder to get him
22 readmitted to hospital?
23 A. Absolutely. And given that we were already were
24 finding difficulties getting people admitted to
25 Muckamore at that stage, it just, it raised real 11:56
26 concerns about his legal protections as well.
27 129 Q. DR. MAXWELL: Can I just ask about the Mental Health
28 Order, if you are a detained patient, who makes the
29 decision to -- presumably there is a legal process to

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1 change your status from detained to guardianship or is
2 that at the discretion of the hospital?
3 A. So there is a process around it. It is so long since I
4 have done one, I am not 100% certain exactly what it
5 is. But certainly while he was a detained patient the 11:56
6 RMO, the Responsible Medical Officer was responsible
7 for the decision making. The re-grading would be done
8 usually in conjunction with an approved social worker.
9 130 Q. DR. MAXWELL: So it's something that would have
10 involved a psychiatrist as well as approved social 11:57
11 workers?
12 A. Yes, mm-hm.
13 131 Q. MR. MCEVOY: You say then, and I think you touched on
14 this a few moments ago, "the placement broke down and
15 as far as I am aware the patient remains at Muckamore 11:57
16 to this day. I believe the placement could have been
17 salvaged if Muckamore had worked with the
18 multidisciplinary team." I know you mentioned it a few
19 minutes ago. Is there anything else you want to say
20 about that? 11:57
21 A. No I don't think so, I think that's everything that
22 needs to be said on that.
23 132 Q. The way you have couched that particular piece of
24 evidence it's clear that you think that the onus was on
25 Muckamore to work with the multidisciplinary team? 11:57
26 A. Mm-hm.
27 133 Q. Why do you say that?
28 A. Because he was a detained patient, they still
29 maintained the responsibility for him.

1 134 Q. Okay. And in paragraph 22, then, you talk about your
2 experience of care of P96 and him being a patient under
3 the Mental Health Order. You say he remained a patient
4 in Muckamore for longer than you believed he needed to
5 be? 11:58
6 A. Absolutely.
7 135 Q. Is there anything more you want to say about why that
8 was?
9 A. No. Again, P96 is a very complex young man with a
10 severe learning disability and autism. He had lived 11:58
11 with his family up until his admission, apart from
12 short periods of respite. We did struggle within the
13 community to find appropriate respite for him.
14 Daycare, he was going to a Trust daycare facility. He
15 was funded for two to one staffing. But actually when 11:59
16 he was admitted then that place was withdrawn and if we
17 could have got the daycare back I think he could have
18 been discharged very, very quickly.
19 136 Q. That's where I was going really. Do you think then
20 that the fact that he has remained in Muckamore for 11:59
21 longer than you believe necessary is attributable to
22 the daycare issue?
23 A. There was nothing else preventing him returning home.
24 137 Q. Okay. Moving then to what you say in your evidence
25 about your role vis a vis the CCTV footage, and you 11:59
26 were appointed to the DAPO role along with two others
27 and then your specific role was to act as lead to
28 ensure safeguarding of patients. You looked at and
29 reviewed the footage released by the hospital to

1 identify any incidents. I suppose for the uninitiated
2 can you sort of explain generally what the DAPO role
3 entails and then specifically with regard to your role
4 vis a vis the CCTV, whether there was any particular
5 adjustment for the role to meet that need? 12:00
6 A. Okay, so the DAPO, under the previously mentioned
7 policy, the role of the DAPO was really to co-ordinate
8 an adult protection investigation so when something is
9 referred in we take on the responsibility of appointing
10 an investigating officer and of chairing any meetings 12:00
11 and we would be the conduit with the PSNI. And quite
12 often with the families, sometimes it can be the
13 investigating officer, but quite often it is the DAPO.
14 I suppose with the Muckamore one we obviously did not
15 realise, no-one did at the time, the scale of it. So 12:01
16 when the first allegation came in, which did relate to
17 P96, we started to look at the CCTV. Obviously we had,
18 naively now, thought it was a one off incident or maybe
19 a couple of incidents. My role as the Adult
20 Safeguarding Lead then was to try and co-ordinate that 12:01
21 investigation and I had two Band 7 social workers who
22 were also DAPOs appointed to help with that. One of
23 them had had considerable experience already in
24 investigating allegations against staff in community
25 settings and the other one was an extremely experienced 12:01
26 social worker. They took on the majority of viewing
27 the CCTV, of completing all the necessary paperwork, of
28 referring through to the PSNI and also then of ensuring
29 that where we could protection plans were put in place.

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1 Between us all, I suppose, we all contacted the
2 families which was very, very difficult because
3 obviously it was a police investigation and we couldn't
4 share with the families what had happened. So often we
5 were ringing, as I said later in my statement, maybe 12:02
6 three or four times a week to say we've found another
7 incident, we found another incident, we found another
8 incident.
9 138 Q. I'll ask you about that in a bit more detail in a
10 moment if that's okay. Turning to, you know, your 12:02
11 description of your relations, I guess, with those
12 responsible at Muckamore for acting as your liaison.
13 At paragraph 24 you said you were made very unwelcome
14 at Muckamore when you were attending to view the CCTV
15 footage. You were given the CCTV footage in a bizarre 12:03
16 way, you say. You talk about being given some footage
17 from March '17 and then the next from September the
18 same year. Now I will be careful here about naming
19 names, can you recall who, without naming names who it
20 was from the Trust or indeed the hospital who was your 12:03
21 liaison? Yes or no I think probably in the first
22 instance and then take it from there?
23 A. I think different aspects of the investigation we would
24 have related to different managers in the hospital.
25 139 Q. Okay. There is a cipher list beside you, it's not 12:03
26 complete but do you recognise any of those names?
27 A. Probably.
28 140 Q. Any of the ciphers?
29 A. Probably those are not the staff that we were dealing

1 with.
2 141 Q. Okay. It may be there is a sheet of paper beside you,
3 if I could ask you to write the names down just on a
4 piece of paper?
5 142 Q. CHAIRPERSON: Can I just ask, were you dealing with 12:04
6 nurses, doctors, administrative staff?
7 A. Administrative staff.
8 143 Q. CHAIRPERSON: Administrative staff?
9 144 Q. MR. MCEVOY: You can put the names down and perhaps
10 their role and I will give you a moment to do that? 12:04
11 145 Q. DR. MAXWELL: Can I ask specifically, there are lots of
12 aspects of this, specifically you say you were given
13 footage?
14 A. Yes.
15 146 Q. DR. MAXWELL: In an interesting order? 12:04
16 A. Yes.
17 147 Q. DR. MAXWELL: Who was responsible for giving you the
18 footage, if you could use a cipher or write the name
19 down?
20 A. So there was a particular member of staff who was 12:04
21 responsible for, I suppose, kind of estates management
22 and it was his responsibility to manage the CCTV. So
23 the system was that the external viewers would have
24 viewed it, those were the retired social workers,
25 nurses or whoever who were brought in. And then that 12:05
26 would have been, if they raised concerns, and most of
27 them had a long history in adult safeguarding, they
28 would have raised concerns and then the DAPOs would
29 have looked at it and whatever.

1
2 148 Q. DR. MAXWELL: Can I just clarify, there was an external
3 team?
4 A. Yes.
5 149 Q. DR. MAXWELL: Of primarily retired social workers? 12:05
6 A. Yes.
7 150 Q. DR. MAXWELL: Who were looking at footage sifting it,
8 triaging it really and deciding what you as the DAPOs
9 would then see?
10 A. Mm-hm. 12:05
11 151 Q. DR. MAXWELL: So it might explain why it was coming in
12 in a strange order?
13 A. I suppose, for me, I would have thought it would have
14 been logical to start with whatever date the cameras
15 started running on and run right through to the end of 12:05
16 it, but that's not what happened. And that was really
17 difficult for family because they were saying well, you
18 told us this incident happened in April, you're now
19 telling us about one in August.
20 152 Q. DR. MAXWELL: I understand why that is difficult but 12:06
21 trying to understand the process, so you got whatever
22 the external group were putting forward to you, so it
23 depends on what they were choosing to put to you and in
24 what order, so it was their decision really what was
25 coming through to you? 12:06
26 A. It was the decision of the estates manager what they
27 viewed as well. So I've said I think in the next
28 paragraph there was no, nothing, no incidents at night.
29 153 Q. DR. MAXWELL: So we need to have a conversation with

1 them about how they received it, what you were getting
2 was what they had filtered and what you needed to see?
3 A. Yes, yes.
4 154 Q. MR. MCEVOY: Can you, maybe for the assistance of the
5 Panel, can you talk about -- 12:06
6 CHAIRPERSON: I think the witness was in the middle of
7 writing down.
8 A. Certainly there is one name I have written down. And I
9 think the others --
10 155 Q. CHAIRPERSON: If you could put their job title next to 12:07
11 the name if you know it.
12 A. I hope people can read my writing.
13 CHAIRPERSON: If you show it to counsel, we probably
14 don't need to look at it further at this stage.
15 Mr. McEvoy, what we will probably do is cipher these 12:07
16 names.
17 MR. MCEVOY: Yes.
18 CHAIRPERSON: And then in due course release those to
19 CPs if it is appropriate.
20 156 Q. MR. MCEVOY: Yes, thank you and thank you, A4. What I 12:07
21 was going to ask you to do, as far as you are able, is
22 to give us, give the Panel an idea of what a session
23 viewing the material looked like for you and your
24 colleagues. I suppose you would go up to the hospital
25 itself? 12:07
26 A. Mm-hm and quite often we would have found difficulty in
27 actually getting into the CCTV room.
28 157 Q. So did you have to make an appointment?
29 A. We had to make an appointment.

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1 158 Q. How far did you have to do it in advance?
2 A. At one stage it was, I think at one stage people were
3 waiting maybe four or five weeks to view it.
4 159 Q. You say people, you and your colleagues?
5 A. Mm-hm. 12:08
6 160 Q. Four or five weeks in advance you had to make an
7 appointment?
8 A. That was four or five weeks where an alleged
9 perpetrator could still have been working on those
10 wards with those patients. 12:08
11 161 Q. All right. So you would attend at the hospital?
12 A. Mm-hm.
13 162 Q. Was a facility, a viewing room made available for you?
14 A. Yes, there was a viewing room set up for us, yes.
15 163 Q. Okay. And was any member of staff on hand then for you 12:08
16 to liaise with in terms of well, we need to see this,
17 we need to see that?
18 A. Initially the name I have written down co-ordinated all
19 of that, however, after a reasonably short period of
20 time the two DAPOs who did most of the viewing actually 12:09
21 just asked to be trained themselves so they weren't
22 then, you weren't waiting, if that particular member of
23 staff was off doing something else, they could go ahead
24 themselves and view it then.
25 164 Q. Was that facilitated? 12:09
26 A. It was facilitated, yeah.
27 165 Q. Was it easy to get to grips with?
28 A. Yeah, easier than we thought.
29 166 Q. CHAIRPERSON: I'm sorry to interrupt, the material that

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1 you were watching had already been watched by the first
2 sift as it were?
3 A. Yes.
4 167 Q. CHAIRPERSON: Then it had been referred to you as
5 potential abuse? 12:09
6 A. Mm-hm.
7 168 Q. CHAIRPERSON: And you would not be getting an
8 appointment for some weeks after that initial
9 assessment had been made that it should be referred to
10 you? 12:09
11 A. Yes.
12 CHAIRPERSON: Yes, I see.
13 169 Q. MR. MCEVOY: How long would a session -- how long would
14 you take in a typical sort of viewing session?
15 A. It really depended on how long the staff could actually 12:10
16 focus on because there would have been numerous
17 cameras, so you might have maybe six cameras covering
18 an area and you might have chosen to switch some of the
19 cameras off, you might have had to go back and review.
20 You had to try and identify staff and identify 12:10
21 patients. Patients were easier because there are a
22 limited number of those, but you would try and identify
23 staff and the DAPOs would have to have matched that up
24 with the staff rotas to make sure.
25 170 Q. That fell to you and your colleagues then to do that? 12:10
26 A. Yeah, quite often we would have had to have called in
27 one of the nurse managers to say can you identify who
28 this member of staff is.
29 171 Q. When you sat down to commence your viewing had you any

1 guidance document, anything from that first sort of
2 sift that you mentioned a few minutes ago?
3 A. There would have been a short synopsis of this is the
4 issue that is causing us concern and then the DAPOs
5 would have to have viewed it, as I say identified the 12:11
6 patient, identify the staff as they could and then fill
7 out, it's called an APP1, it's the referral form for
8 adult safeguarding, fill the detail out on that and
9 then, because it related to staff, they then would have
10 completed the adult joint protocol referral to the 12:11
11 PSNI. So a lot of paperwork. And then try and ensure,
12 try, they would have linked with perhaps the service
13 manager in the hospital or one of the senior nurses
14 around what a protection plan might look like, because
15 that's really the role of the DAPO is to develop that 12:11
16 protection plan and make sure that that patient is kept
17 safe.
18 172 Q. Okay.
19 173 Q. CHAIRPERSON: Sorry, one other question, did you get
20 information about the patient who was concerned in each 12:11
21 incident, so you would know what their -- triggers is
22 probably the wrong word but behavioural patterns were?
23 A. I think that probably developed as the investigation
24 developed as well but, yes, we would have asked for
25 copies of any relevant assessments and behaviour 12:12
26 support plans and things like that.
27 CHAIRPERSON: Thank you.
28 174 Q. MR. MCEVOY: Okay, just in terms then of you mentioned,
29 I told you I would take you back to it, but the issue

1 around viewing CCTV at night. We are not necessarily
2 interested in what was on CCTV of course but for the
3 purposes of this issue, but just in terms of being told
4 as you say in your statement by staff there were no
5 incidents at night. I mean, and again not naming 12:12
6 names, but who or at what level of staff member were
7 you told that by?
8 A. It was the staff member whose name I have written down.
9 175 Q. Okay, that's helpful. Now, a few moments ago you had
10 gone on to say, as you said, about the reporting 12:13
11 process and the conversations that you had with the
12 relatives of those involved. You say then in paragraph
13 26 that:
14
15 "Each time I saw something I had to call the patient's 12:13
16 family. I had to call some families three or four
17 times a week."
18
19 Who decided that process, and by that I mean each time
20 you saw something that it was a separate phone call 12:13
21 rather than, if you bear with me, a sort of a round up
22 in other words, going to phone family of patient
23 whoever, phone them on Thursday afternoon and tell them
24 based on what we've seen recently this is cumulatively
25 the number of incidents? 12:13
26 A. That would have been driven very much by the families.
27 Some families wanted to know immediately.
28 176 Q. Right?
29 A. And I think particularly in the early days, so that

1 kind of August, September 2017 when we started to
2 realise the scale of it, people did think it was a one
3 off.
4 177 Q. Yes?
5 A. Or maybe it was a couple of incidents and then 12:14
6 obviously, particularly for P96 and a couple of the
7 other patients within the PICU ward, it became obvious
8 that it was much more than that. We also offered home
9 visits where it was appropriate.
10 178 Q. Yes? 12:14
11 A. But it was very much driven by the families. I mean I
12 am very, very acutely aware, I do remember ringing one
13 mother and saying, you know, 'I have seen an incident,
14 I can reassure you that your loved one did not seem to
15 have been physically harmed by this, I can't tell you 12:14
16 anything more than that'. She went 'okay, right,
17 fine', and two hours later phoned back and said 'what
18 did you just tell me?' So you were leaving people with
19 half a version of things.
20 179 Q. Yes? 12:15
21 A. Some families, certainly P96, his father was very
22 clear, 'just ring me at the end of the week' and he
23 would have wanted the date and the time and some kind
24 of, you know, was it a push, was it a shove, was it a
25 physical assault, what was it, so you could give 12:15
26 outlines of what had happened. That would have been
27 his preferred way of working. Others just found it
28 very, very stressful. Some were saying 'well, look,
29 don't tell me anything more until you've everything

1 together'. But it was driven by the families rather
2 than by any policy.
3 180 Q. Thank you. So, at paragraph 27 then, and this is
4 something I think Dr. Maxwell has already maybe touched
5 on with you, in or around late 2017, early 2018, the 12:15
6 number of patients in Muckamore was down to around 50
7 you tell us. You were asked by the Trust to go to
8 Muckamore to see why those remaining had not been
9 discharged. Then you said:
10 12:16
11 "When I asked to see patient assessment files to
12 include occupational therapist and social worker
13 assessments, there were no documents available."
14
15 I suppose so we're clear, what was it, if anything, 12:16
16 that you were actually provided with?
17 A. Quite often there was nothing. Now Belfast has the
18 electronic PARIS system and the assessment should have
19 been on there. There was nothing on it. It was quite
20 often the nursing assessments would have been very 12:16
21 outdated. And as, I said earlier, when I spoke to the
22 social workers it was, well, it's all included in the
23 nursing assessment which it's not right, that's not
24 right, social work assessments are a very different
25 document from nursing assessments. They just weren't 12:16
26 there on many occasions.
27 181 Q. DR. MAXWELL: Can I just ask you about that, because
28 you've talked about professional leadership and
29 professional responsibility, how is it that a social

1 worker would not record their assessment, you know,
2 that seems like an issue, a professional issue if they
3 didn't?
4 A. Yeah, absolutely, and certainly within community
5 settings, as you know, social workers would have 12:17
6 operational and/or professional, depending on how they
7 are managed, supervision. And there would be, you know
8 when I was a team leader, you would have audited a
9 number of files every month and checked that all of
10 that was there. So I don't know why that happened. 12:17
11 182 Q. DR. MAXWELL: Is the hospital social workers saying
12 that they weren't doing their professional assessments?
13 A. That probably wasn't articulated as clearly as that.
14 183 Q. DR. MAXWELL: They were saying they weren't doing
15 written assessments, their comments were incorporated 12:17
16 into nursing?
17 A. Yes.
18 184 Q. DR. MAXWELL: Which seems unusual?
19 A. Absolutely.
20 185 Q. CHAIRPERSON: And the same with the OTs? 12:18
21 A. That's why I was surprised looking at it.
22 186 Q. DR. MAXWELL: As Mr. Kark says, did you speak to the
23 occupational therapists as to why they didn't have
24 assessments?
25 A. Because my remit was only the social workers, I didn't. 12:18
26 187 Q. DR. MAXWELL: You say you were looking on the
27 electronic record and my understanding is actually,
28 just this week South Eastern Trust is getting very
29 excited about its hopefully all singing, all dancing

1 encompass but actual there hasn't been a full
2 electronic record in Northern Ireland until last week
3 and now it is only in South Eastern Trust. Is it
4 possible that those assessments were on paper and you
5 just weren't able to access them? 12:18
6 A. We asked for that and there were no paper copies
7 either. And again, I mean I know there has kind of
8 been this indication of Muckamore being a place apart.
9 In Learning Disability in Community we had been on
10 PARIS for many, many years and Muckamore wasn't 12:19
11 incorporated onto that. When I say all adult services,
12 I think most adult services in Belfast were on PARIS
13 for a considerable number of years, but it was only
14 relatively recently that Muckamore was also included in
15 it. 12:19
16 188 Q. CHAIRPERSON: Could I just ask you, who were you
17 asking, again without naming a name for the
18 assessments?
19 A. The ward manager, we met with the ward managers across
20 all -- 12:19
21 189 Q. CHAIRPERSON: In relation to each patient that you were
22 considering?
23 A. Yes, that wasn't under treatment.
24 190 Q. CHAIRPERSON: It wasn't just one occasion?
25 A. No, no, it was every ward. 12:19
26 191 Q. PROFESSOR MURPHY: So are you saying that for these
27 last 50 odd patients, that there was so much resistance
28 to them being discharged that people were deliberately
29 not co-operating?

1 A. I don't know I would go so far as to say they were
2 deliberately not co-operating. I think there was more
3 a sense of so many of them had failed placements, it
4 was nearly like it had become an inevitability that
5 these remaining patients, with the exception probably 12:20
6 of the Six Mile patients, probably were going to be
7 there for the rest of their lives.
8 192 Q. PROFESSOR MURPHY: Was it your impression that this was
9 partly driven by nursing staff not wanting to lose
10 their jobs, because presumably that was something that 12:20
11 was a major worry to them?
12 A. I didn't get that impression. There certainly was a
13 sense of people in community will never be able to
14 manage these remaining patients, but I had never got
15 the impression that it was around them maintaining 12:20
16 their jobs.
17 DR. MAXWELL: Okay, thank you.
18 193 Q. MR. MCEVOY: Okay, and then this is at paragraph 28
19 then you talk about the investigations into the
20 treatment on the Ennis ward in and around 2019 you say 12:21
21 in your statement but --
22 A. 2012 I think it was.
23 194 Q. You say that you weren't directly involved:
24
25 "But for me this was a key moment that highlighted the 12:21
26 divide between Muckamore and community Trust social
27 workers."
28
29 Now the Inquiry is going to hear evidence about those

1 investigations and so on in due course but, in terms of
2 your own evidence, why do you say that those
3 investigations were a key moment? I know you said
4 earlier in your evidence that you were given some idea
5 of the outcomes. Can you tell us a bit more? 12:21
6 A. I think it was really only when I kind of reached the
7 Operations Manager level that I actually really
8 understood what had happened in Ennis. I mean I knew
9 the investigation had gone on. I suppose when I
10 reached the Operations Manager and in particular as the 12:22
11 Adult Safeguarding Lead, there were many -- I
12 understand that there were recommendations made around
13 Ennis and concerns raised that did not seem to have
14 been addressed. I think this sense that I had was that
15 if those had been addressed in 2012 then perhaps what 12:22
16 happened or what has been found in 2017 may not have
17 happened.
18 195 Q. Finally then just towards the end of that paragraph, in
19 fact at the end of that same paragraph, you say:
20 12:22
21 "It seems many staff at Muckamore are related and I
22 understand when staff raised concerns they were moved
23 to another ward and often fell ostracised."
24
25 Would you like to expand on that? 12:23
26 196 Q. CHAIRPERSON: We need to know what your source is for
27 that, what is the basis for saying that I think?
28 A. I certainly had a staff member who no longer works in
29 the service, who I tried to get to come back and work

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1 with me and she very clearly said that when she had
2 raised a concern that she was removed from that ward to
3 a ward that she didn't particularly feel she had the
4 skills to work in. And there was a general kind of
5 feeling that she had crossed a line and was made to 12:23
6 feel very unwelcome and actually left the service
7 altogether in the end.
8 197 Q. CHAIRPERSON: Did that that seem to be related to the
9 staff who remained on the ward and who were related?
10 A. Absolutely. 12:24
11 MR. MCEVOY: Okay. A4, those are my questions arising
12 from the open part of your statement, which is most of
13 it.
14 CHAIRPERSON: We'll have to go to paragraph 10
15 obviously and deal with that but I think Dr. Maxwell 12:24
16 has a question.
17 198 Q. DR. MAXWELL: I want to take you back to when you first
18 started looking at the CCTV after it had been
19 identified and you as DAPO and other DAPOs was looking,
20 obviously it was important because of the allegations 12:24
21 that there was a speedy and effective investigation,
22 but it must have been quite unsettling for the staff
23 and even though we have heard a tremendous number of
24 allegations, not all staff were involved in some of
25 these allegations. What support was given to the 12:24
26 hospital staff at what must have been a very unsettling
27 time for them so they felt enabled to assist you in the
28 investigation?
29 A. I understand that they had counselling services were

1 brought in for them. Obviously occupational health was
2 brought in. I think it was a really difficult period
3 for the staff. We know there were very good staff and
4 where we saw good practice, we highlighted that good
5 practice as well. I think in fairness to the staff, 12:25
6 and perhaps even up until now, because they don't know
7 the details, there was a level of disbelief that this
8 could have been happening. And the more incidents that
9 were reported and the more staff who were under
10 investigation, the more difficult it became. I think 12:25
11 there were a number, and I'm sure some of my colleagues
12 when they give their evidence will highlight staff who
13 wanted to change practice and who recognised that if we
14 were saying things were wrong, that there were things
15 that needed to be done, there were other staff who were 12:26
16 openly hostile towards us, openly resistant, they would
17 not come to meetings with us. And as DAPOs, the
18 staffing is not an issue for a DAPO, that is for the
19 hospital management. Our responsibility is to try and
20 make sure that the patient is kept safe. But a number 12:26
21 of the ward managers would not attend meetings. The
22 resistance from the senior management became much
23 greater, one of the reasons that I left the Trust after
24 35 years of working there.
25 199 Q. DR. MAXWELL: So when you had resistant staff who 12:26
26 wouldn't come to meetings, what was the process for
27 dealing with that?
28 A. That would have been raised through the co-director and
29 the service manager. However, much of the resistance

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1 to what the safeguarding team were trying to do came
2 from them as well.
3 200 Q. DR. MAXWELL: I am wondering what happened outside the
4 hospital because ultimately it's the Trust Board that's
5 responsible, how -- were you able to raise things 12:27
6 further up the Trust, up to and including the Executive
7 Director of Social Work that actually your
8 investigation was being impeded?
9 A. Yes, and a lot of those were raised through the
10 divisional social worker who, I would have to say, did 12:27
11 hold us to account but also did her absolute best to
12 raise concerns and to raise that profile with the
13 Executive Director of social work and right up to the
14 Chief Executive.
15 201 Q. DR. MAXWELL: And how early in your viewing of CCTV do 12:27
16 you think the Executive Director of Social Work was
17 aware that you weren't getting full co-operation?
18 A. From fairly early on, from fairly early on.
19 202 Q. Okay, thank you?
20 CHAIRPERSON: All right. Sorry, do you have anything? 12:28
21 PROFESSOR MURPHY: No, I don't.
22 CHAIRPERSON: I think we have asked the rest of our
23 questions as we have gone along. So I think we now
24 need to deal with paragraph 10 in closed session. So I
25 am going to ask for -- this is technical stuff you 12:28
26 don't need to worry about. So I am going to ask for
27 the feed to Room B to be cut. Only those who have
28 signed confidentiality undertakings are allowed to
29 remain in this room and anyone watching online. I know

1 the secretary to the Inquiry can check, will have
2 access who has signed a confidentiality agreement. Can
3 I just remind everybody of the importance, first of
4 all, of respecting the anonymity order, but also just
5 to remind people generally that they have signed a 12:29
6 confidentiality undertaking, the material that is going
7 to follow is highly sensitive, it must not be published
8 or repeated in any form whatever.
9
10 IN RESTRICTED SESSION 12:29
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12 LUNCHEON ADJOURNMENT
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1 THE HEARING RESUMED AS FOLLOWS:
2
3 IN OPEN SESSION:
4
5 CHAIRPERSON: Yes, right, good afternoon. 14:28
6 MS. TANG: Good afternoon, Chair, Panel. This
7 afternoon the Inquiry is going to be hearing the
8 evidence of
9 Dr. Shelley Crawford, she is joining us this afternoon
10 on Zoom. 14:28
11 CHAIRPERSON: Doctor Crawford, can you see and hear us?
12 We can't hear you at the moment.
13 WITNESS: Yes, I can hear you and I can see you, yeah.
14 CHAIRPERSON: Excellent. The camera is going to switch
15 back now to Ms. Tang who is going to take you through 14:28
16 your evidence but first of all I think we are going to
17 ask you to take the oath. So have you got somebody
18 with you in the room who is going to assist you with
19 that.
20 WITNESS: Yes, I have Laura Boyd with me. 14:29
21 CHAIRPERSON: That's a member of the Inquiry staff.
22
23 DR. SHELLEY CRAWFORD, SWORN, QUESTIONED BY MS. TANG:
24
25 CHAIRPERSON: Thank you. Finally can you just confirm 14:29
26 is there anybody else in the room with you apart from
27 Inquiry staff?
28 WITNESS: No, just Laura Boyd from the Inquiry team.
29 CHAIRPERSON: Excellent, thank you very much.

1 203 Q. MS. TANG: Thank you Shelley. You and I met a short
2 time ago again and we spoke briefly last week but just
3 to remind you, I am Shirley Tang, I am one of the
4 Inquiry counsel.
5 14:29
6 Thank you for giving your statement to the Inquiry.
7 Can I check that you have a copy of that in front of
8 you?
9 A. Yeah.
10 204 Q. Thank you. I am going to read your statement into 14:29
11 evidence and once I've done that, if you are content to
12 adopt that statement as your evidence to the Inquiry
13 then I have some questions for you. So if I can ask
14 you just to listen for a short time while I read in
15 your statement. Page reference for the statement for 14:30
16 the Panel is page 044, beginning at page 1. The
17 statement is dated the first day of August 2022.
18
19 "I Shelley Crawford make the following statement for
20 the purpose of the Muckamore Abbey Hospital Inquiry." 14:30
21
22 And there are no exhibits with your statement.
23 Moving to Section 1:
24
25 "My connection with MAH is that I was seconded to work 14:30
26 as an occupational therapist or OT for a number of
27 years employed by the Belfast Trust or BHSCT for the
28 purposes of the resettlement scheme of service users.
29 The relevant time period that I can speak about is

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1 between 4th December 2012 to the 30th September 2015.
2 During this period I was off for a year on maternity
3 leave in 2014 returning in September 2015 and I
4 subsequently left the post shortly thereafter.
5 14:31
6 I was seconded to MAH with another colleague, H726. We
7 were both OTs from a community background dealing with
8 learning disabilities or physical disability. We were
9 seconded to MAH as part of the resettlement programme.
10 My time working at MAH was largely a positive 14:31
11 experience as we were able to engage with and support
12 the resettlement agenda. I loved being able to see the
13 benefits for the service users upon resettlement and
14 being able to follow up with patients once they were
15 resettled. 14:31
16
17 Both H726 and I had a lot to add to this role from our
18 community backgrounds as we were able to advise on the
19 resettlement placements that were available for the
20 service users and assist in identifying their 14:32
21 environmental, functional and sensory needs, et cetera.
22 This was a very positive and rewarding experience.
23
24 When I first moved to MAH in December 2012, I was taken
25 aback by the culture. H726 and I started in the Ennis 14:32
26 ward. H726 looked at me and said 'what do we do here?'
27 The staff mentality seemed to be that we were there to
28 take their jobs. This was not the case as our
29 intervention was time limited and only focused on the

1 resettlement process. Occupational therapy had not
2 been a service that MAH had offered for a very long
3 time and there had been no OTs for approximately 30
4 years prior to the appointment of H726 and I.
5 I felt that the staff at MAH had a very sceptical 14:32
6 attitude towards the resettlement process, at least
7 initially.
8
9 There was input from a physiotherapy service, however
10 they had little or no access to specialised wheelchair 14:33
11 training that was available and commissioned regionally
12 for OTs. This was because across the region, OTs would
13 provide this type of assessment and equipment with the
14 exception of MAH. The physiotherapists at MAH could
15 not access the OT specific training around specialist 14:33
16 seating and it is unclear if they knew how to access
17 the resources associated with the wide array of
18 wheelchairs and custom moulded seating available at
19 that time.
20 14:33
21 It was evident that the majority of service users with
22 highly complex and destructive postures were in
23 inappropriate wheelchairs and static chairs. For
24 example, standard transit and self propelling wheel
25 chairs when their needs would have been better met with 14:33
26 individual custom contoured seating or highly modular
27 seating options. My colleague and I addressed these
28 needs as swiftly as we could.
29

1 There was resistance from the staff towards the
2 resettlement process and we were faced with comments
3 such as 'no-one will look after our babies as well as
4 we do'. We offered reassurance that there would be
5 betterment for the patients if they were resettled into 14:34
6 the community. There was a multidisciplinary team
7 focused on resettlement which worked very well
8 together, working to tight deadlines around
9 transitioning patients into the community.
10 14:34
11 The general ethos around ward staff was not of
12 assistance to the resettlement process. Ward based
13 staff did not seem invested in this process when we
14 took up post initially. This did improve as time went
15 on as we were able to report how service users were 14:34
16 adapting to community living.
17
18 MAH was a strange set up, although it was part of the
19 BHSCT it was in a remote location and was very isolated
20 from the rest the Trust. I met many employees at MAH 14:34
21 who seemed to have only worked at MAH and they appeared
22 to be institutionalised, i.e. resistant to change with
23 limited experience of employment outside of this
24 setting. A lot of them had trained there and had never
25 been beyond MAH. There was a lot of resistance towards 14:35
26 us initially and it was not the easiest of jobs to
27 begin with. A lot of the staff simply didn't know what
28 benefits OTs could offer but with support and
29 reassurance most staff became very receptive and

1 appreciative of our input and we were able to develop
2 very positive relationships with the majority of staff.
3 I recall one occasion when I went to do a routine
4 personal care assessment with a service user, P49.
5 This involves the OT assessing how much assistance a 14:35
6 service user needs with washing, dressing, showering,
7 et cetera, and looks at equipment and strategies that
8 can be introduced to increase independence. The OT can
9 then recommend what level of assistance from a care
10 package is required for community living, et cetera. 14:35
11 The nurse questioned why I was carrying this out. I
12 cannot recall her name. She thought it was creepy that
13 I was doing this assessment. However this was just a
14 lack of understanding of our role. But I do remember
15 being taken aback by the lack of knowledge that this 14:36
16 individual had in relation to the basic roles of other
17 healthcare professionals.
18
19 The staff were often concerned about where they would
20 be redeployed to once the wards closed. It was unclear 14:36
21 what support was offered to the staff with such
22 significant changes that were coming into their working
23 patterns and potential job moves.
24
25 I recall that a lot of the staff members were related, 14:36
26 such as a husband and wife, brother, and sister,
27 cousins and even a brother and sister-in-law.
28
29 There was an incident that H726 witnessed and told me

1 about. This was at an earlier part of my time at
2 Muckamore, I cannot recall the exact date. H726
3 witnessed a gentleman being moved and handled in an
4 incorrect way by a healthcare assistant, I cannot
5 recall her name. The patient's needs were not being 14:37
6 cared for optimally. There was a lack of dignity. The
7 incident was potentially uncomfortable for the service
8 user and we discussed this and we both reported it.
9 This was reported to H212, the ward manager on the
10 Rathmullan ward, I cannot recall his surname. He did 14:37
11 seem concerned and stated that he would prevent the
12 member of staff coming back on the ward as they were
13 not usually on Rathmullan ward and were just covering.
14 It then transpired that this was his sister-in-law who
15 was incorrectly handling the gentleman. We often 14:37
16 shared this concern with the physio assistant H719 to
17 ensure that if this member of staff returned that she
18 was able to ensure that the patients were being
19 adequately moved and handled in the event that OT was
20 not present on the ward. I expected some feedback from 14:37
21 the ward manager in respect of this incident raised, I
22 was not given any feedback. However, I don't recall OT
23 noticing the staff member working on Rathmullan ward
24 again thereafter.
25 14:38
26 We were on the wards that were identified for
27 resettlement five days per week. These included wards
28 such as Rathmullan, Greenan, Oldstone, Erne and Ennis.
29

1 I was the professional supervisor to the Band 6 OT,
2 H716 who was employed to cover the assessment and
3 treatment wards such as Cranfield and Donegore. We
4 were not funded to provide input to the Intensive Care
5 ward. I understand H212 moved to the Intensive Care 14:38
6 ward once Rathmullan closed and he would have been very
7 keen to have OT input in the Intensive Care ward as he
8 recognised the complexity of the service user's needs
9 and the need for an MDT approach. Unfortunately we
10 were not in a position to offer the input at that time. 14:38
11
12 H716, a Band 6 OT, reported an incident to me that she
13 was concerned about. She had witnessed an incident
14 that at the time distressed her. I recall the pool
15 attendant, H213, often banked in other areas at MAH and 14:39
16 on this occasion, as far as I can recall, he was
17 involved with a patient in the gardening area of the
18 day opportunities unit. H716 informed me that he had
19 booted a patient up the backside and used swear words
20 towards him. I documented this in her supervisory 14:39
21 notes. I then went to the service manager, H77, to
22 note our concerns about the safeguarding of the service
23 users. We did not hear anything back. This incident
24 did not sit well with me and I felt it was potentially
25 humiliating for the service user. I then went to the 14:39
26 service manager, H77, again when I witnessed H213
27 smoking at a site at the back of the pool. This was
28 against Trust policy. I was faced with the response
29 that I must have been incorrect in my report as he was

1 smoking an e-cigarette. Regardless this was also
2 against Trust policy and should not have made a
3 difference as to how this report was dealt with.
4
5 I queried when I spoke with H77 what had happened about 14:40
6 the incident with H213 kicking the patient. His
7 response was that the OTs didn't understand the banter
8 at MAH and that the other staff members had developed a
9 relationship and a rapport with the patients. In my
10 view this was simply unacceptable behaviour. I was not 14:40
11 happy with that outcome. I felt that H77 portrayed a
12 lack of interest and unwillingness to do something
13 about the incidents and that mine and H716's concerns
14 were dismissed.
15 14:40
16 I was concerned that these incidents were not being
17 dealt with adequately. I reported this to the
18 safeguarding social worker, H188, I think this was his
19 name. He did host an informal training session for us
20 on safeguarding and the process, procedure, et cetera 14:41
21 and how it was reported, what we needed to know and how
22 it was investigated at MAH. All OTs had the relevant
23 basic training in adult safeguarding. He was
24 supportive and showed us examples of the documentation
25 in relation to safeguarding procedures. 14:41
26
27 It may have become evident that OTs were vigilant and
28 willing to raise concerns. For example, we had to
29 telephone ahead to some of the wards to tell them we

1 were coming. These wards included Cranfield, Donegore
2 and some other wards.
3 We were allowed on some wards unannounced but the norm
4 seemed to be that the staff preferred it when we
5 telephoned ahead. This could also be, of course, so 14:41
6 that the staff could prepare the service users of our
7 planned visits as some service users may have required
8 preparation for a visit from another professional.
9 When OTs tried to arrange assessments on occasions
10 staff came back to say that the patients were in 14:41
11 distress and that we couldn't attend the ward at that
12 time. The challenging behaviour of service users, now
13 known more as distress behaviours, was a new area to
14 H726 and I and we would have liked to have assessed the
15 service users, even if they were distressed, to 14:42
16 determine if I could assess potential reasons or
17 triggers and discuss some strategies that may have been
18 helpful in reducing their distress. At that point we
19 were new and did not challenge the prior telephone call
20 to the wards in the first instance. 14:42
21
22 It was hard being in a new service and trying to
23 establish a new role as well as building relationships
24 against some initial resistance.
25 14:42
26 There was a complete lack of visibility as to how
27 things were investigated or followed up when issues
28 were raised, however we were in a difficult position as
29 we were trying to build relationships with people and

1 staff members that were resistant to the process as
2 well as highlight some issues.
3 We simply wanted to get the service users out into the
4 community and resettled. I often found the patients
5 dealt better with the change than the staff did. I 14:43
6 don't know what perception the staff had or what
7 training they had, but some were not very receptive to
8 the resettlement process. I enjoyed showing the
9 patients their new homes or placements, it was very
10 rewarding. The patients were very excited at seeing 14:43
11 their new homes, but this enthusiasm was not always as
12 evident with some of the staff.
13
14 When I first arrived at MAH there were some issues or
15 concerns in relation to the service users' seating and 14:43
16 position tour on Greenan ward. The ward manager, H214,
17 was initially quite resistant to us but did quickly
18 come round to our role once we explained it and we
19 explained how we could improve the service users'
20 comfort, function and pressure care needs. 14:43
21
22 When we first arrived on the Greenan ward all of the
23 service users were sitting in comfort chairs ordered
24 from a local company. Each chair had sewn on a belt
25 that was made onsite at MAH attached to their Chair 14:44
26 cushion. The technical officer, or TO, and the on site
27 seamstress made these belts at the request of
28 clinicians. The materials would have been purchased
29 via the physiotherapy or orthotics budget. They may

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1 not have been aware that there were commercially
2 available alternatives that would have been better and
3 more comfortable alternatives. Again this knowledge
4 sits more with OT and as there were no OTs prior to our
5 posts, this likely accounts for this. We said to him 14:44
6 'don't be making any more belts' and he was delighted
7 when we told him to stop making the belts. The belt
8 came up between the patient's legs and they were
9 strapped into the Chair. I had never seen anything
10 like it. I asked to see the documentation around the 14:44
11 purchase of the chairs as I could see that these chairs
12 were not meeting the service users' postural needs.
13
14 Most service users were issued with comfort chairs that
15 they had paid for themselves, all from the one company. 14:45
16 They should not have paid for this by themselves as if
17 this was an assessed need the Trust would have to meet
18 their needs and would have provided the appropriate
19 chairs and maintenance of same. There were various
20 comments made by ward staff that the service users had 14:45
21 built up a lot of money and could be buying what they
22 need. Again OT explained that these service users
23 should be entitled to the same assessment and provision
24 to other service users within the BHSCT.
25 14:45
26 Every single service user in Greenan had a comfort
27 Chair, not so much in Rathmullan. The patients spent
28 long periods of time in these chairs. This would not
29 have been comfortable, as many were not correctly

1 prescribed. In addition the physiotherapist
2 technicians had simply ordered wheelchairs that were
3 basic wheelchairs that didn't meet the individual
4 patients' needs which the physio technicians fully
5 acknowledged and they were very happy to have the OTs 14:46
6 as part of the MDT who would complete all seating and
7 wheelchair assessments going forward. We were left
8 with all of these chairs that were not fit for purpose
9 that were paid for by the patients. The Trust had not
10 purchased these chairs and could therefore not recycle 14:46
11 or reuse them once OT provided more suitable
12 alternatives, which was usually a specialised
13 wheelchair that would meet postural, functional,
14 pressure care and mobility needs. Comprehensive OT
15 assessments were needed as some of the service users 14:46
16 needed moulded seats placed on wheelbases.
17
18 I did report my concern about misappropriation of
19 patient finances to H717, my supervisor, the
20 Occupational Therapist Manager For Learning 14:46
21 Disabilities and Mental Health. I felt this was
22 bordering on financial abuse. As far as I can recall
23 she had indicated that she had mentioned this concern
24 with the co-director of MAH at the time, I can't recall
25 who this was, but I am not aware if this went any 14:47
26 further. My manager at the time was very supportive.
27 I was deeply unhappy that the patients were purchasing
28 their own chairs and that these were not fit for use
29 for the patients.

1
2 This was very distressing for me at the start of the post as we had to redo all of the assessments. The physiotherapist may not simply have had access to an equipment budget. It was well intentioned but these were not fit for purpose. 14:47

8 There were two physiotherapists at MAH at the time but I cannot recall their names. They may have retired in or around the time I was there. I did meet at the training course I was delivering at the time and they were open and honest that they had been encouraged to order the chairs and that they simply didn't have access to the training. The only professionals in the BHSCT where you can access such trainings is if you are an OT. 14:47 14:47

18 The physiotherapist manager at the time was H718 and was not always on site and/or available for joint working when I took up my post. H719 and another physiotherapist technician, H720, at the time and they were very helpful and around worked very closely with the OTT. 14:48

25 The most basic models of wheel chairs were being ordered. These cost in the region of £300 but a lot of patients needed wheel chairs such as a tilt and space with specialist back rests, head rests and other accessories at the cost of up to £2,500. What the 14:48

1 staff were ordering was not out of the ordinary
2 therefore I don't believe this would have been picked
3 up by anyone i.e. a community OT manager, as the
4 wheelchairs would still have been funded by the OT
5 wheelchair budget. 14:48
6
7 Many patients had extreme contractures and were in
8 chairs that simply didn't meet their needs. The
9 community OT managers from the BHSCT would have
10 oversight of the wheelchair budget but would never 14:48
11 query a basic wheelchair and would have been unaware of
12 the needs of a patient at MAH as there was no OT there
13 prior to my post. I came from that directorate and I
14 was not aware of or had knowledge of what the patients'
15 needs were in MAH in relation to seating, posture or 14:49
16 other equipment.
17
18 There were a number of behaviours displayed on the
19 wards, for example many of the patients displayed
20 mirroring behaviour. If one took their clothes off, 14:49
21 the other did. There was a pressure cooker of distress
22 as wards often had many patients in close proximity to
23 one another. Often when patients from MAH were
24 resettled to smaller, quieter environments, those
25 behaviours reduced or disappeared. The patients were 14:49
26 impacted by their physical and social environment. The
27 older wards were generally not ideal in terms of space
28 and design and had many patients.
29

1 there was a tendency to use restrictive practices that
2 were not typical. When we arrived they wanted us to
3 splint a patient's arms out so they could not hit their
4 head with their hands. This was not appropriate and
5 not an intervention OT would consider and it would not 14:50
6 have solved the issue. There also seemed to be a lack
7 of knowledge from staff in respect of the belts on
8 static chairs. Approximately 90% of them were removed
9 from the chairs when OT reviewed this and provided
10 alternative seating. There were commercial belts 14:50
11 available and these were only put in if as a last
12 resort and in line with restrictive policy and
13 guidelines.
14
15 H726 and I asked to see the documentation supporting 14:50
16 the belts. We wanted to see the documents on
17 restrictive practice. When we opened the nursing care
18 plan medical notes there was simply a small paper
19 clipped to the front stating that it had been signed
20 off by the consultant psychiatrist. We immediately 14:50
21 started to work on devising new documentation for such
22 restrictive measures that were based on the clinical
23 need and showed the process and clinical decision
24 making around reaching the need for a restrictive
25 intervention including risks, benefits, best interests 14:51
26 et cetera. This was then discussed and signed off by
27 MDT and family if the patient was unable to consent.
28
29 We were surprised that such a basic process with this

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1 documentation was not in circulation prior to the
2 decision being taken to use a restrictive practice on a
3 patient. We routinely carried this out and discussed
4 this at length in the community practice. There is a
5 restrictive practice register that was held by 14:51
6 psychologists and this was reviewed regularly in the
7 community setting. It was not clear if or how MAH
8 reviewed this at the time I took up post. There was no
9 robust process with regards to this clinical decision
10 evident in the care plans that I could see. They 14:51
11 needed stimulation and engagement in meaningful
12 activities on the wards and this may have prevented the
13 service users from wanting to go attempt to get out of
14 the chairs.
15 14:52
16 When we started the resettlement process we first
17 looked at those with physical disabilities as we were
18 able to assess them and get their equipment ordered for
19 resettling them. Then I focused on patients who
20 displayed distressed behaviours and offered strategies 14:52
21 and advice. H716 would have had more insight into the
22 acute assessment and treatment wards. I would
23 sometimes accompany her on wards such as Cranfield,
24 Donegore and Six Mile if she needed support.
25 14:52
26 Not all my time in MAH was negative. I recall there
27 were some really good, supportive members of staff such
28 as H215, 216 and H217 in the Greenan ward, they were
29 excellent. In the Donegore ward the ward manager, H721

1 was great. There was also a compassionate nurse in the
2 Rathmullan ward and I believe he was H219.
3
4 A small number of staff members that I encountered in
5 MAH seemed less committed to the patients. They 14:53
6 appeared too easy-going and laid back.
7
8 I left MAH after a few weeks when I returned from
9 maternity leave in 2015..."
10 14:53
11 And you go on to then say you moved to a post
12 elsewhere. Your colleague, H716, the Band 6 OT, also
13 left when she got a promotion. You go on to say:
14
15 "I did enjoy my time at MAH but I could not have stayed 14:53
16 there as I had a fear I would become institutionalised
17 too. MAH did realise that they needed an OT once they
18 were no longer funded by the resettlement money. The
19 posts were retained. The culture needed to change in
20 MAH. They needed to think more broadly. I don't think 14:53
21 there was an intentional resistance to the community
22 placements, but there was a lack of knowledge as to how
23 patients' lives could be changed and reassurance was
24 offered at all times.
25 14:53
26 I believe that after a while we were able to reassure
27 the staff members at MAH around the resettlement of
28 patients as we had experience in the community setting.
29 The patients would have much more freedom and would be

1 encouraged to be more independent. By way of example,
2 the patients were often passive observers in
3 situations. Shopping was an activity that staff
4 members claimed to do with patients. Patients would
5 attend with the staff member to go shopping but they 14:54
6 were never taught how to even use the self-scanner et
7 cetera. The staff members would carry out these
8 activities rather than actively engaging in the
9 activity with the patient. We would often have six
10 week independent living programmes where the patients 14:54
11 learned the skills to be independent such as cooking,
12 budgeting, et cetera. We found that staff would
13 suggest to us that the patient was able to cook as they
14 would cook a fry every Friday morning. It would then
15 transpire that the ward staff cooked the fry and sat 14:54
16 with the patients to eat this. This made it very
17 difficult to assess when you were not being given the
18 entirety of the facts. The staff members'
19 interpretation of the patients' functional ability was
20 very different to what OT assessed. 14:55
21
22 I recall that there were two male patients with whom we
23 conducted one of these six week programmes. They hated
24 it when the programme ended as they had enjoyed it and
25 learned so much. This type of programme helped to 14:55
26 prepare the service users for resettlement. Once the
27 service users were resettled I would often complete one
28 or two follow up visits to monitor progress and check
29 equipment et cetera and for the most part service users

1 managed their transition to community living very well
2 and enjoyed the increased freedom and more
3 opportunities for community integration."
4 You go on to describe your working arrangements since
5 you left MAH and finally you conclude with your 14:55
6 comment:
7
8 "My passion would always be within learning disability
9 and I am glad now to be back working in this area."
10 14:55
11 Your statement concludes with your preferences in terms
12 of giving evidence and a statement of truth, a
13 declaration of truth.
14
15 Can I confirm with you, Shelley, that you are content 14:56
16 to adopt the contents of this statement as your
17 evidence to the Inquiry?
18 A. Yes.
19 205 Q. Thank you. I just have some questions for you then
20 coming out of your statement. Just to begin first of 14:56
21 all when did you first start working as an OT?
22 A. I qualified as an OT in 2001, so that's over 20 years
23 ago.
24 206 Q. Can you help the Panel just to clarify, what can an OT
25 offer when it comes to assisting people with a learning 14:56
26 disability?
27 A. We would do a very holistic assessment so we would look
28 at their baseline functioning, we would look at their
29 strengths, their challenges, what areas of activities

1 of daily living that they would need support with. We
2 can look at strategies around equipment. We can teach
3 them new ways of doing things. We would look at their
4 sensory processing. We would look at some of their
5 behaviours to see is that related to the environment, 14:57
6 is it related to becoming overwhelmed by, I suppose,
7 sensory stimuli. We would look at the whole breadth of
8 things that would impact on that individual that has a
9 learning disability. So it's quite a broad remit.
10 207 Q. Can I also clarify would it be common for you to carry 14:57
11 out that work within a multidisciplinary team that may
12 include psychologists and other professions?
13 A. Yes, it would.
14 208 Q. What other professions would you expect to be typically
15 in a multidisciplinary team in a learning disability 14:57
16 setting?
17 A. What you would expect to find within the learning
18 disability setting would be obviously social workers,
19 OTs, if it was in the community setting or we work very
20 closely with our community learning disability nurse 14:58
21 colleagues. We would work closely with psychology as
22 well. I would work very closely with my speech and
23 language therapy colleagues, podiatry colleagues. I
24 suppose the whole breadth of a multidisciplinary team,
25 that's what you would expect. 14:58
26 209 Q. Were those professions all part of the
27 multidisciplinary team that you describe in MAH?
28 A. It was, within the resettlement though I suppose there
29 would have been social worker, care management, nursing

1 representation, probably less Psychology input,
2 although we would have input more in relation to
3 Psychology on the assessment and treatment wards. From
4 memory my colleague that I supervised, the Band 6,
5 would have done a lot more joint working with 14:59
6 Psychology.
7 210 Q. Okay, thank you. Whenever you were seconded to MAH can
8 I check, I presume from what you've written in your
9 statement that you were already working from Belfast
10 Trust at that time; is that correct? 14:59
11 A. I was working within the Community Learning Disability
12 Programme of care at that time.
13 211 Q. But employed by Belfast Trust in that programme?
14 A. Yes.
15 212 Q. I understand when you started work at MAH were you 14:59
16 based on the hospital site five days a week or were you
17 coming from elsewhere?
18 A. No, we were based up at the Muckamore site.
19 213 Q. And you have mentioned a number of wards in your
20 statement where you did provide OT assessments and 14:59
21 input, were there any ward areas where you never would
22 have set foot? I know Intensive Care was one that you
23 mentioned, was there any others that you wouldn't have
24 been in that you can recall?
25 A. Intensive Care would have been the main one because we 14:59
26 weren't funded for that. Myself and the other clinical
27 lead at the time, we were only funded purely for the
28 resettlement ward. So any ward that was deemed a
29 resettlement ward we would have had input into. And

1 the OT that I supervised, she covered the acute
2 assessment and treatment ward and Six Mile which I
3 think was a forensic ward at the time.
4 214 Q. Okay. For clarity, there was no OT input to Intensive
5 Care, at least for some of the time when you were 15:00
6 there?
7 A. Yes.
8 215 Q. Okay. You have mentioned resettlement and I want to
9 move on to talk a wee bit more about that, please.
10 Before you came to MAH you were working in a Community 15:00
11 Learning Disability Team. Was that focusing on
12 resettlement as well, i.e. looking after people who had
13 been resettled or what was your experience of
14 resettlement before you came to MAH?
15 A. When I worked in the community team I wouldn't have had 15:01
16 much input into resettlement. There was the odd client
17 maybe that was transitioning out of the Iveagh Centre
18 at the time, but I wouldn't have been involved in much
19 of the resettlement to do with Muckamore until I
20 actually physically went and worked in Muckamore. 15:01
21 216 Q. Okay. So was that your understanding of why you were
22 being seconded to Muckamore, to focus on resettlement?
23 A. Yes and that's why I applied for the secondment post
24 because I would have been very interested in, I suppose
25 being part of a team that ensured that individuals got 15:01
26 the best community placement that met their needs.
27 217 Q. Now, you mention in paragraph 5 of your statement that
28 you describe being taken aback by the culture when you
29 got to MAH. Can you just tell me a wee bit more about

1 what was so, what made you stand back, what surprised
2 you?
3 A. I suppose I was quite surprised coming new into it,
4 coming from a community background where I suppose the
5 norm was, you know, facilitating people to live in 15:02
6 supported living or their own home with support. And
7 then I suppose in Muckamore it was, they were quite
8 resistant to that so they didn't feel that the
9 individuals potentially would be able to make that
10 transition or they weren't confident that the services 15:02
11 were there. And I think I suppose coming from the
12 community setting, I wouldn't have felt the same
13 because I knew of the services, I was familiar with the
14 services, the supported living, the residential, the
15 nursing care that was available in the community. So I 15:02
16 was quite taken aback that those staff members weren't,
17 didn't have any awareness of what was available. So it
18 seemed as if geographically they were quite far removed
19 even from what was available.
20 218 Q. Would it be fair to say that the resettlement agenda 15:03
21 had been in place for a number of years before this?
22 A. That's my understanding, yes.
23 219 Q. So is it the case, do you think, that the staff that
24 you initially encountered didn't believe in
25 resettlement or were they just not very familiar with 15:03
26 it, what's your sense?
27 A. I think both. I think there were staff members that I
28 suppose just didn't understand what was available. But
29 there were some staff members I think that were

1 resistant to it, that they didn't feel that any service
2 would be able to meet the needs of the service users or
3 the patients, the same way that they were able to meet
4 those needs. So I suppose there was that quite
5 paternalistic feeling almost that they didn't want them 15:03
6 to move on because they were fearful that they wouldn't
7 be able to be supported in the same way. And I think
8 there was also, I suppose when our posts came into play
9 I think they realised that the resettlement agenda,
10 there was a big push then to, I suppose, work closer to 15:04
11 the deadlines and try and resettle people quicker. I
12 think staff at the time, some staff would have
13 expressed that they were concerned about their future,
14 their jobs, what that might mean for them. And I
15 suppose before our appointments I'm not sure how much 15:04
16 support and training or information they were provided
17 in relation to that, they didn't really disclose that
18 to us.
19 220 Q. You indicated, I think, in or around paragraph 5 also
20 that you had largely positive experiences at MAH, for 15:04
21 all that you encountered initial scepticism around
22 resettlement. Can you say a bit more about the kind of
23 positive experiences that you did have when you were
24 there?
25 A. I think the staff were, once they accepted you and you 15:05
26 explained your role and why you were there and they
27 were no longer suspicious of you, I did enjoy doing the
28 assessments for the clients. I really loved being able
29 to, I suppose, be part of the decision making around

1 which placement would best meet their needs, taking
2 them to view those properties or placements, that was
3 really, really enjoyable. And for the most part, once
4 staff got to understand what your role was and that you
5 were there trying to help the patients, they did come 15:05
6 round and you were able to build those relationships as
7 time went on. And I suppose the resettlement piece was
8 quite a focused piece so it was a nice team. There was
9 a nice MDT feel to that. So I did enjoy it, I enjoyed
10 the whole piece around the environmental design and 15:06
11 making sure the individuals had enough space, their
12 sensory needs were met, their equipment needs were
13 kept, it was quite rewarding. I quite liked the pace
14 of the work as well because it was a time limited
15 piece. 15:06
16 221 Q. Did you find, working as an OT, that you frequently had
17 to explain to other professional groups what OTs do and
18 what they were for?
19 A. Very much so and I think traditionally there would have
20 been an OT service from what I can recall about 30 15:06
21 years before us. I suppose that role would have been
22 focused more on day opportunities and maybe less the
23 role it is today, so there was a real lack of
24 understanding of what occupational therapists could
25 offer and what our role was. And I can understand, 15:06
26 having not had that professional role within the
27 service, there was a lot of scepticism around you are
28 taking part of our job, or, do you know, a bit of
29 blurring of roles and stuff. But that can be

1 anticipated and we were able to work through that but
2 there definitely was, I would have expected them to at
3 least have had some knowledge of what we would have
4 been able to offer. So it was going in and being able
5 to, I suppose, reassure and I suppose educate the staff 15:07
6 and carve out your role. So the first few months would
7 have been quite difficult but I suppose it's quite
8 difficult in any setting when you're setting up a new
9 service to do that.
10 222 Q. Yes, that's interesting actually. I wanted to probe 15:07
11 that a little bit further with you. Would you say your
12 time at MAH in terms of setting up that new service,
13 did you meet a different reaction there than you would
14 have anywhere else that you have worked or is it fairly
15 in your experience that when you go to work as an OT 15:08
16 that you have a bit of introductory time with people to
17 get them used to you?
18 A. I think the time in Muckamore, it took us a bit longer
19 than it normally would. We had to, I suppose, reassure
20 staff a lot more that we weren't there to, I suppose, 15:08
21 resettle the clients therefore doing away with their
22 job. You know, we would have been saying things like I
23 know when resettlement is finished in whatever, I can't
24 remember when the target was, 2015, you know, we'll be
25 back to our posts, we won't be here either, it's a time 15:08
26 of change for everybody. You know, if we like it here
27 we won't be able to stay here either. The service
28 users have a right to transition into the community.
29 So I suppose, the resettlement agenda as well as the

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1 new staff coming in, I think staff, it took them longer
2 to adjust to that as well as I suppose trying to
3 educate them what our role was in terms of how things
4 had been done before we came.
5 223 Q. Do you think was there an element of fear of change? 15:09
6 A. I got that sense. You know, that I suppose having
7 spoke to some of the staff that were there that they
8 had only ever worked there, they had maybe trained
9 within that setting many years ago. They had never
10 worked outside Muckamore at the time. So I think 15:09
11 people were a wee bit insular and maybe weren't looking
12 at the breadth of services that potentially could be
13 offered. So I think there was, I suppose, resistance
14 to change. But some staff members did come on Board,
15 you know, when you were able to feed back and say 15:09
16 'oh, I was out visiting such and such and such', maybe
17 they had been discharged for two months, 'they are
18 getting on really great, they are involved in this day
19 opportunities programme'. And, you know, they did seem
20 genuinely happy for them eventually [drop in feed] -- 15:10
21 being able to be make inroads I suppose sooner than
22 what we did.
23 CHAIRPERSON: We lost you for a moment. You told us
24 they were involved in this day opportunities programme
25 and they did seem genuinely happy for them eventually 15:10
26 and then we lost you.
27 A. Yes, and then we would have fed back about how the
28 service users were getting on in their new house and
29 their new day opportunities and the staff would have

1 seemed happy to hear the positive feedback and all I
2 said then was I think we did make inroads in terms of
3 reassurance, but it did take longer than potentially it
4 would in any other new service.
5 224 Q. MS. TANG: Can I ask, are you conscious that before you 15:11
6 and your colleague were working in that resettlement
7 agenda, for patients who had been successfully
8 resettled before, was there any feedback coming back
9 into the hospital to say how they were getting on or
10 did staff not necessarily know what happened once the 15:11
11 patients left hospital?
12 A. I'm not sure, Shirley, I can't remember conversations
13 around that.
14 225 Q. Okay, was it something that whenever you did come into
15 post you were very deliberate about that you wanted to 15:11
16 provide that or is that just the way the thing was
17 moving anyway?
18 A. We wanted to provide that reassurance because I sensed
19 it was needed. And from the outset if somebody was
20 being, I suppose, resettled to a supported living 15:11
21 placement, the chances are when I worked in community
22 learning disability I was familiar with that facility
23 or with that placement so I was able to say oh, you
24 know, 'that wee patient I think will do really well,
25 because that area is located really close to a really 15:12
26 good day opportunity which I think would meet his
27 needs'. You know, 'it is on a main bus route, you
28 know, I think with some support' -- you were able to
29 make it very clear what additional opportunities the

1 service users would have had access to, because I would
2 have been familiar with a lot of the supported living
3 and placements available through my time working within
4 that community setting prior to Muckamore.
5 226 Q. So you were able to bring that information to the 15:12
6 hospital?
7 A. Yes, yeah.
8 227 Q. Whenever you think back on the resettlement agenda that
9 you were working on then during your time in MAH, would
10 you have said that all of the patients or virtually all 15:12
11 of the patients were suitable for some form of
12 resettlement over time or would there have been a
13 cohort that was not realistic for resettlement?
14 A. It's difficult to categorically, I suppose, answer
15 that. I do think that there was, and I don't know, 15:13
16 maybe still are, but at that time there was some
17 patients with very high support and unique needs and it
18 was very difficult trying to find an appropriate
19 placement for them. It was very difficult trying to
20 find the right, I suppose, forever home for them, the 15:13
21 right environment and the right level of support or
22 support package, especially if it was quite, we would
23 call bespoke, so outside traditional placements. So
24 you were having to be quite creative as to how you can
25 support some of these I suppose service users in the 15:13
26 community.
27
28 So, I don't know whether I would say it's fair to say
29 that it couldn't be done but certainly some of the

1 patients it would have been more difficult because of
2 the level of need and the level of distress that they
3 may have been displaying at that time.
4 228 Q. Would you say that there was an expectation that it
5 would at least be considered for all the patients, 15:14
6 albeit for some it would be harder to do than others,
7 or were there some that you had the sense it was really
8 not considered because the complex needs were such?
9 A. I don't remember ever assessing a patient in Muckamore
10 and saying it couldn't be done. 15:14
11 229 Q. Yes?
12 A. But I suppose sometimes it's really difficult to get
13 care packages for those service users that have really
14 high support needs and you really need a very skilled
15 staff team that would understand, you know, things like 15:14
16 sensory processing, the features of autism and how to
17 support that and, do you know, it's very difficult and
18 still is in my current workplace, it can be difficult
19 to find those packages of care.
20 230 Q. And how common would you say it was for a package, once 15:15
21 it had been put in place, for that package to break
22 down or fall through in some way?
23 A. There would have been the odd one in my time there that
24 would have maybe needed re-admitted or whatever but for
25 the most part, so for the wards where there was mostly 15:15
26 a physical disability, so that would have been Greenan
27 and Rathmullan. For the most part I don't remember any
28 of those placements really breaking down in my time.
29 In fact I visit a place in Armagh at the minute and I

1 see one of the service users is still there that I
2 would have been involved in back in 2012. Because,
3 obviously, I was only there a short time, I don't know
4 how many of those placements would have broke down
5 maybe from the other wards. 15:16
6 231 Q. Okay?
7 A. But my sense is even a lot of the clients that would
8 have had fairly high support needs in the likes of
9 Ennis ward, a lot of those individuals I think were
10 resettled successfully. Now how many resulted in a 15:16
11 readmission two or three years later, I don't know what
12 that looks like.
13 232 Q. I understand. Just in general, if you could help us
14 understand are there certain factors that make it more
15 likely a placement will not succeed or issues that are 15:16
16 more common?
17 A. I suppose, for me, the two core things are getting the
18 physical environment right. So that's the home.
19 Whether the individual is, you know, getting the right
20 space, the right environment in the right location and 15:17
21 then the social environment, who is that individual
22 sharing with, are they able to share with anyone,
23 should they be on their own. And the level of social
24 support, i.e. the staff team, so the skill and
25 expertise of the staff team. I think if you get those 15:17
26 two crucial elements right and then you do a really
27 good hand over and training to support that transition
28 back into the community, that's your best chance of
29 getting that to be successful. That's not to say down

1 the line an individual may not take unwell or become
2 distressed or even physically unwell that may
3 jeopardise the placement. But, by and large my view
4 would be if you get the right physical environment, as
5 in the right home and the right social support, that's 15:18
6 the best chance and that if the MDT then support that
7 with, I suppose, training and expertise and support
8 that transition, follow up on that transition, then
9 that has the best chance of success.
10 233 Q. In terms of those two factors you mentioned, the home 15:18
11 environment and the social environment, were those
12 things that were a feature of your work as a
13 multidisciplinary team when you were at MAH and were
14 any of them a particular challenge or what was your
15 recollection of how you dealt with those? 15:18
16 A. It was very much a core feature of our assessment. We
17 would have looked at the environment, you know, if
18 someone displayed a lot of distress would you have been
19 looking is that space big enough if they need
20 assistance of two, is there a second exit if staff need 15:19
21 to withdraw into a different room, or they need to
22 support that individual with a safety intervention as a
23 last resort. You would be looking at I suppose the
24 physical environment in quite a bit of detail. We
25 would have looked at support packages in detail so does 15:19
26 a client need one to one, two to one. And then
27 obviously what providers were available. I suppose,
28 and I don't know that much has changed today, there is
29 a lack of housing, there is a lack of placements.

1 234 Q. That's what I wanted to -- sorry, o on ahead.
2 A. And obviously social care, there's, you know, sometimes
3 accessing the care provider can be difficult because
4 they are not generally paid very well and sustaining
5 that social care is a big challenge and continues to be 15:19
6 so. And at that time I think those were very real
7 challenges that I recall of. You know, we would say
8 this individual needs a bungalow, stairs are too much
9 of a risk but maybe there wasn't one available so you
10 were always trying to resourceful around well, you 15:20
11 know, can I manage that risk, can we not manage that
12 risk as a team, do we hold off and wait for something
13 more appropriate. So you were always trying to make
14 decisions but trying to work against what was a very
15 tight deadline for resettlement as well. 15:20
16 235 Q. Can I just finish on that one by checking, were there
17 occasions whenever a resettlement was delayed because
18 either suitable accommodation wasn't available or the
19 social care package for whatever reason couldn't be put
20 in place? 15:20
21 A. I recall, yes, there would have been a number of
22 delayed discharges for that reason because I suppose we
23 were keen not to set a patient up for failure, so to
24 resettle them into an environment that wasn't right or
25 with the wrong social support would ultimately, I 15:21
26 suppose, have the potential to lead to a placement
27 breakdown, a readmission, which is obviously quite
28 traumatic and another transition for the service users.
29 Many of the patients don't do well with change. So you

1 want to make sure that the transition, if at all
2 possible, is the main, the one transition to their
3 forever home rather than multiple transitions.
4 236 Q. I want to move on now to talk a wee bit about the use
5 of aids and equipment when you were at MAH because you 15:21
6 make some observations about access to wheelchairs and
7 suitable seating and use of belts and things like that.
8 Thinking about the specialised wheelchair situation
9 that you speak of in your paragraph 6. You mention
10 initially there was little or no access to specialised 15:22
11 wheelchair training amongst key staff. Is that the
12 case that because the OTs hadn't historically been
13 there for some time that that would have been the
14 obvious source of that training, do I understand you
15 right? 15:22
16 A. Yeah, so regionally OTs hold the wheelchair budget so
17 all of the commissioned training for wheelchair
18 provision and static seating would be directed through
19 occupational therapy. So because there was no OTs
20 there I suppose the physio staff would acknowledge that 15:22
21 they didn't have the right training and didn't have
22 access to that training so they weren't very happy when
23 we came into post, because it would be well known that
24 we would be the ones that can access that training at
25 postgraduate level. 15:23
26 237 Q. You used a phrase in paragraph six "highly complex and
27 destructive postures." Can you help me understand what
28 that actually means?
29 A. What that means is people with, you know, high levels

1 of contractures in their upper limbs and their lower
2 limbs.
3 238 Q. And a contracture --
4 A. They might have curvatures of the spine, they may have
5 scoliosis, kyphosis, tight hamstrings, reduced hip 15:23
6 flexion, poor head position, muscle imbalance,
7 involuntary movements, so really quite difficult to
8 seat within standard seating because they would be
9 fixed and have a lot of contractures tours.
10 239 Q. So if I understand you correctly they needed tailored 15:23
11 seating for whatever their individual situation was?
12 A. Yes. A lot of them would have needed what we would
13 call moulded seating, where they are placed in casting
14 bags and you then take a laser image of that shape and
15 their seating is made in a customised way. So, you 15:24
16 know, we would call it moulded seating, it is moulded
17 out of foam or whatever and again OTs would be the ones
18 that would have access to those clinics. So, I suppose
19 the clients probably didn't get access to those clinics
20 until we came. 15:24
21 240 Q. And for somebody who had a particular issue like the
22 types of postures that you described, to have them
23 sitting in a standard Chair, what effect would that
24 have, what would that do to them?
25 A. They would inherently feel very unstable, very 15:24
26 uncomfortable, very unsupported, and it would limit
27 their ability to function so they may not be able to
28 engage or interact as well because they would be
29 spending all their energy trying to stay upright or

1 trying to stop themselves potentially from sliding from
2 the chair. They would fatigue very easily. They may
3 be more prone to pressure ulceration or pressure damage
4 because they would be loaded maybe on one greater to
5 counter one ischial tuberosity, with the moulded 15:25
6 seating we can offset that and we can balance that and
7 I suppose provide total contact. So really from a
8 comfort point of view, I don't think, they wouldn't
9 have been very comfortable.
10 241 Q. Was this a large number of patients that would have 15:25
11 been in this situation or was this a very particular
12 cohort of the patients there?
13 A. It probably would have been the majority of, from
14 memory, Greenan ward and the majority of Rathmullan
15 ward, so two wards. One was a female ward and one was 15:25
16 a male ward. I can't remember how many patients would
17 have been on each ward but, yeah, so that was our
18 starting point was we found we just didn't want people
19 being in discomfort and we knew that obviously with
20 equipment it can take some time to come and because we 15:26
21 were working to tight deadlines we wanted to get all
22 the equipment needs met so that if suitable placements
23 were to become available that the patients didn't lose
24 out on that because their equipment wasn't ready.
25 242 Q. Okay. You go on then to mention the topic of belts 15:26
26 that were initially manufactured at Muckamore and
27 attached to the chairs, that was in paragraph 18, can
28 you just help me understand what are the belts
29 typically for, what are they meant to do?

1 A. Well I suppose a belt on a static Chair or comfort
2 Chair would only be used and should only be used if you
3 are moving the patient from room to room, otherwise it
4 should be released. There is the odd time where you
5 can put it on to maintain their posture but that's 15:27
6 different because that's a commercially available
7 postural positioning belt that's not deemed a
8 restraint, it's there to stabilise the pelvis so that
9 the client can function and have full use of their
10 upper limbs. But these belts weren't postural 15:27
11 positioning belts. They were I thought quite
12 restrictive. They were sewn into the chair and they'd
13 came up between the groin. My view was it seemed to be
14 custom and practice that everybody got one for fear
15 that they would potentially slide out of the chair. 15:27
16 But if the seating is correctly prescribed they
17 shouldn't slide out of the chair.
18 243 Q. So would you say this was linked to the fact they were
19 the wrong chairs, so they then needed the belts to stop
20 people ending up on the floor? 15:28
21 A. I think so, and I think it was a bit of well. They all
22 have them, it was sort of like everybody who got a
23 chair just got one, they didn't realise that
24 potentially most of them didn't need them.
25 244 Q. How did the patients respond to the belts, how did they 15:28
26 cope with them?
27 A. I suppose by the time we came they were just used to
28 them, they didn't seem to object to them. But with
29 more appropriate seating we were able to remove and

1 secure 90% or even more of those belts on those chairs
2 because they were undignified looking. What bothered
3 me was for women who maybe wore wee skirts or dresses
4 and then you have a great big groin strap coming up, I
5 didn't think it was appropriate and it was not 15:29
6 something that we would have provided in the community.
7 If they need a belt they would get a nice padded body
8 point belt, one that is fitted at a certain angle for a
9 specific function. Whereas these were all just sewn
10 into the Chair and I just didn't think they were very 15:29
11 dignified, particularly for the ladies.
12 245 Q. Did you get a sense from the staff that you interacted
13 with on the wards that they weren't happy with these
14 belts at all or did they not see a difficulty with
15 them? 15:29
16 A. They didn't really see it as -- they didn't see it as
17 an issue. We sort of said, you know, we would be
18 taking away a lot of these belts and changing the
19 seating, they were again initially quite suspicious,
20 how are you going do that, they need those belts. I 15:29
21 said no, the seating is probably not appropriate and if
22 they are better supported they won't slide and
23 therefore they won't need the belts. They were
24 initially quite resistant but I think when they seen
25 the outcome of the assessment and the new solution, the 15:30
26 new seating solution I think they did come round.
27 246 Q. Okay. The last bit of equipment that you referred to
28 picks up in paragraph 18 was the use of the comfort
29 chairs. I haven't heard that term before, what does

1 that actually mean, what is a comfort chair?
2 A. We would, in OT we would call that a static chair, so a
3 chair that usually would have tilt in space, it can
4 have lateral supports, it can be customised to a
5 certain degree to the individual. But in Muckamore 15:30
6 they called them comfort chairs but I remember my first
7 day on the ward I said 'but they don't look very
8 comfortable to me'. These clients need moulding
9 seating, some of them, because even though this is a
10 highly specialised Chair it is still not providing the 15:31
11 support. So I suppose we would call it static seating,
12 you know, I suppose for people who don't know, it's
13 those specialised chairs that OTs would provide in
14 nursing homes and things, you can tilt the client back,
15 you can open up the seat to back angle, you can put on 15:31
16 laterals, you can put on different back rests, you can
17 support the head for feeding, that type of thing. I
18 suppose the concern for me was that all of the chairs,
19 particularly on Greenan, came from one company whereas
20 we would generally use a variety of companies, you 15:31
21 know. So you would always try a range of chairs to
22 make sure you get the right solution.
23 247 Q. You mentioned in I think it was paragraph 18 that you
24 understood that the patients had bought those chairs
25 themselves rather than that they had been provided by 15:31
26 the Trust. How many chairs roughly do you think that
27 was?
28 A. I think nearly every patient at that time who was on
29 Greenan ward who couldn't mobilise would have had a

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1 Chair purchased from that company. I don't know, maybe
2 ten or more. But that's a guess now, I couldn't say
3 that accurately, but a lot.
4 248 Q. Is it your understanding that of those, say it was ten,
5 that all of those patients had bought those chairs 15:32
6 themselves or just maybe some of them or what was your
7 understanding?
8 A. At that time it was my understanding that the patients
9 in those chairs had purchased them themselves, that's
10 what I was told because if we purchased the Chair 15:32
11 through the OT equipment budget, there would be an
12 asset code on it, so we would be able to trace it.
13 249 Q. Yes?
14 A. When I tried to return the chairs to the Trust for
15 recycling and reissuing, it transpired they didn't 15:33
16 belong to the Trust and that's when I said where did
17 these chairs come from and it was like the clients here
18 buy their own chairs.
19 250 Q. When you say you were told that, was that ward staff or
20 who was telling you that the patients bought them? 15:33
21 A. I think it was the ward staff would have told us that.
22 251 Q. Did you challenge that with the ward staff and the
23 appropriateness of that or what happened?
24 A. I just remember saying at the time that's very strange
25 because, you know, if that's an assessed need then in 15:33
26 other areas the Trust would meet that need. So those
27 clients at that time they were, the patients were
28 living in Muckamore, that was their home. If they were
29 living in a nursing home that assessed need would have

1 been met by the Trust. So I did say I thought that was
2 very strange and I remember, I can't remember who the
3 conversation was with and it was like no, no, the
4 patients when they are here, and again I don't know how
5 any of the finances work or whatever, they accrue a lot 15:34
6 of money and therefore, you know, that's a way of
7 spending it. And I did say well, again, to me that's
8 not ideal because the assessed needs should be met
9 through our budget the way it typically would be.
10 252 Q. You mentioned that you raised, you reported that 15:34
11 concern about what you described as misappropriation of
12 patients' finances and you used the phrase bordering on
13 financial abuse. When you reported that concern do you
14 remember if you used that type of language when you
15 reported it to H717? 15:34
16 A. I probably did because would I have been quite cross
17 and taken aback that I suppose they had spent the money
18 and the chairs weren't suitable, I think I was annoyed
19 at that. So I probably would have used that, those
20 terms. 15:35
21 253 Q. And did you get any response from MAH staff following
22 that report?
23 A. I know that my manager would have felt very similar and
24 she would have, I think she did say I'll raise that
25 because I don't think she was very happy about it 15:35
26 either and I think she did raise it with a co-director
27 at the time but I don't remember anything ever, I don't
28 remember any feedback from that.
29 254 Q. Did you raise it with the ward staff themselves that

1 you felt this was inappropriate?
2 A. From memory, I did and I think I remember raising it
3 with the ward manager on Greenan ward initially and I
4 was told well, the physio was involved with that and
5 she was here, you know, two days a week. And I think I 15:36
6 remember saying well, there's two of us and we're here
7 five days a week and they won't be paying for their
8 seating and their posture anymore if it's an assessed
9 need.
10 255 Q. Did the practice stop once you did that as far as you 15:36
11 know?
12 A. We would have met all their seating and posture needs,
13 so there would have been no need for them to purchase
14 anything else.
15 MS. TANG: Dr. Maxwell, one of the Panel members, has a 15:36
16 question so we are going to turn the camera so you can
17 see her.
18 256 Q. DR. MAXWELL: Did you talk to the physiotherapist
19 directly about this practice?
20 A. There was very little overlap between ourselves, if 15:36
21 any, and the physiotherapist who were there. I think
22 one had already retired and one retired soon after we
23 started. But I did meet them at a training course, I
24 can't remember, it must have been maybe even before I
25 took up the post in Muckamore and they did say they 15:37
26 were doing seating but they did acknowledge that they
27 didn't really want to be doing it because they didn't
28 feel they could access the right training.
29 257 Q. DR. MAXWELL: I understand that and I recognise that

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1 occupational therapists are the experts in this area,
2 but having found what you considered to be very poor
3 practice, when the ward staff told you that the physio
4 had been involved did you discuss it with any of the
5 physios or did you raise it with the physiotherapy 15:37
6 manager?
7 A. I can't remember. I must have had conversations
8 because there was a physiotherapy manager but it did
9 seem to be acceptable that they could use their own
10 finances. 15:37
11 DR. MAXWELL: Okay, thank you.
12 MS. TANG: Thank you. I should say, I probably have
13 got another 15 minutes of questions, are you happy for
14 me to continue or --
15 CHAIRPERSON: Could I just have the witness, the 15:38
16 camera? Dr. Crawford, how are you feeling? Are you
17 happy to go on or would you like, we normally take a
18 little break now, so we can either take 10 minutes now
19 or we can carry on for about 30, how do you feel?
20 A. I am okay to continue. 15:38
21 CHAIRPERSON: If at any stage you'd like a break will
22 you just let me know and we can stop straight away, all
23 right?
24 A. Okay, thank you.
25 258 Q. MS. TANG: I am going to, I just wanted to touch 15:38
26 briefly on the restrictive practices. You had
27 referenced in paragraph 28 the comment that.
28
29 "There was a tendency to use restrictive practices that

1 were not typical, not appropriate and would not have
2 solved the issue."
3
4 To your knowledge was there a Trust policy on
5 restrictive practices at that time? 15:39
6 A. There would have been a Trust policy on restrictive
7 practices at that time, yeah, as far as I know.
8 259 Q. So do you recall having seen it at any point when you
9 were at Muckamore?
10 A. I'm trying to think, there would have been a Trust 15:39
11 policy on restrictive practices, yeah, as far as I am
12 aware.
13 260 Q. Okay. So I think probably just in terms of your time
14 in Muckamore do you recall people referring to it or,
15 referencing it at all whenever they were in their -- 15:39
16 A. I don't recall. Now I don't know on some of the other
17 wards during ward rounds or things whether they would
18 have referred to it, I don't recall much reference to
19 it.
20 261 Q. Okay. In that paragraph 28 you had also mentioned that 15:40
21 there was a request as to whether the OTs would splint
22 a patient's arms to stop them hitting themselves in the
23 head and the face. What other approach would have been
24 a better one from an OT perspective, what would you
25 have done in that scenario? 15:40
26 A. Sorry can you repeat that it froze a wee second there,
27 Shirley.
28 262 Q. Of course. It's in paragraph 28, you mentioned that at
29 one point you were asked to consider splinting a

1 patient's arms to stop them hitting themselves. I
2 wondered was there a better approach to doing that,
3 what would an OT typically recommend if they were
4 presented with that problem?
5 A. Well obviously we wouldn't do that, that's highly 15:40
6 restrictive and I was quite shocked when I was asked to
7 do that. So what we would do in that instance is
8 assess the individual, see why they are hitting their
9 head, what is the cause of the distress, is it the
10 environment, is it they are overwhelmed, is it they 15:41
11 don't understand what's happening. So the answer is
12 looking at what's causing it, not trying to prevent
13 them from doing it, you know, using splints. So I
14 suppose we would have looked at a very holistic
15 assessment to see if we can understand why that 15:41
16 individual was becoming so distressed in the first
17 place. Rather than being reactive, it is trying to do
18 a robust assessment so you are proactive.
19 263 Q. Did you see the use of splints like that in place with
20 any other patient during your time at Muckamore? 15:41
21 A. No, I didn't.
22 264 Q. And you didn't agree to do that one from what you've
23 said?
24 A. No, absolutely not.
25 265 Q. You've just touched on challenging behaviour there, I 15:41
26 want to quickly ask you about that. At paragraph 27
27 you refer to a pressure cooker of distress with
28 patients very close to each other and older wards being
29 more challenging environments, I guess. Would you say

1 that the pressure cooker that you describe, was that
2 environmental or was that to some extent a staff to
3 patient ratio issue as well?
4 A. It's very hard to know and it could be many, it could
5 be multifactorial. But the environment was 15:42
6 particularly poor in some of the older wards. So there
7 was very little personalised space for individuals. A
8 lot of the rooms would have been, the spaces would have
9 been communal, so if one service user was distressed a
10 lot of the service users were distressed. There may 15:42
11 have been a lot of learned behaviour, 'when Joe Bloggs
12 does this I'll do this'. A lot of mirroring
13 behaviours, really poor environment, really old wards.
14 I suppose they wouldn't have had a lot of access to
15 space that they could go to regulate and have some time 15:43
16 to themselves. I don't know about the staff ratio. I
17 suppose if there had have been more staff sometimes
18 that's not always the answer, it's not going to make a
19 difference, it is just more people, if the physical
20 environment isn't right. But I suppose if there was 15:43
21 more staff they could have redirected the service users
22 who were distressed, maybe, to another area. But the
23 issue was there wasn't very many other areas where you
24 could have redirected individuals to, to become more
25 regulated. 15:43
26 266 Q. Okay. Thank you. The last topic that I want to take
27 you through is in relation to safeguarding. You had
28 mentioned some incidents particularly and I just wanted
29 to probe those a little bit further with you if I may.

1 You say at paragraph 13, you describe a situation where
2 a colleague, your OT colleague, described seeing a
3 member of MAH staff booting a patient up the backside
4 and using swear words to him and that you had
5 documented that and reported it to the service manager, 15:44
6 H77. Whenever you reported that to H77 do you recall
7 it being treated as a safeguarding incident?
8 A. Yes, at the time where we went over to obviously raise
9 that as a concern at that time it seemed oh, that's,
10 yes, we'll look into that, that will be fully 15:44
11 investigated. You know, we were given assurances that
12 that would be the case and we would have said is there
13 anything else we need to do, do you need any more
14 detail from us? No, no, that's not acceptable. It was
15 treated as if it was -- very seriously and thanked us 15:45
16 for coming forward and obviously raising that but then
17 it was what happened afterwards was a bit strange.
18 267 Q. Could I just clarify, did you get any further contact
19 with H77 or any of the ward team about that incident?
20 A. No. 15:45
21 268 Q. Nothing?
22 A. And that's why I then raised it again because I would
23 have expected that the member of staff that I
24 supervised maybe would have been called back or
25 interviewed or asked for more detail or -- and I did 15:45
26 say look, I've made a record of it in her supervision
27 notes and I'll probably share that with my line manager
28 as well because to me that's quite significant.
29 269 Q. From what your colleague told you, it was described by

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1 one of the ward staff as banter potentially and part of
2 the rapport with patients. Did your colleague get the
3 sense that it was in any way banter and a bit of carry
4 on with the patient?
5 A. I think she said you could construe it that way, but 15:46
6 above all it is not acceptable, you can't kick someone
7 and swear at them because there is always a
8 professional boundary, it was as if the boundary had
9 become very blurred. You know, you are there to
10 support those service users to provide care to them, 15:46
11 not to be their best friend. There seemed to be a
12 blurring of those roles. So even if it was banter I
13 still don't think that that's any way acceptable.
14 270 Q. Can I go on then to paragraph 15, you mention reporting
15 concerns that incidents were not being properly dealt 15:46
16 with to the safeguarding social worker, H188. Can you
17 recall roughly how long after your initial report to
18 H77 you went and spoke to H188 about your concerns that
19 the safeguarding incidents weren't being properly dealt
20 with? 15:47
21 A. I couldn't be sure.
22 271 Q. Okay. Do you think, are we talking a number of weeks
23 or potentially longer?
24 A. I don't think it would have been longer than a couple
25 of weeks. 15:47
26 272 Q. Okay. My last question for you, you will be glad to
27 hear, is looking at paragraph 16 where you had to phone
28 ahead to some of the wards to let them know you were
29 coming. Do you know why that was? Did they explain to

1 you in particular why they wanted you to do that?
2 A. Well the first thing was you can't access the wards. I
3 think they were, you needed a fob to access them so we
4 didn't have one, so we had to phone and tell them we
5 were coming. You wouldn't actually physically have 15:48
6 been able to access some of the wards. And I suppose,
7 you know, some of the clients maybe who would have
8 autism maybe would not -- needed prepared in advance
9 maybe for you coming, maybe through visual supports and
10 things like that, so I understand that. But I suppose 15:48
11 it started not to sit well whenever they were saying
12 oh, they were distressed. I think one time we did say
13 can we come across and see that because we need to know
14 what that looks like because we will be trying to
15 support these individuals in another environment and no 15:48
16 no, they were too distressed. So I did find that a bit
17 strange. But again when you're new and a ward manager
18 tells you not to come, you don't really feel you can I
19 suppose overrule that. But I suppose nowadays I
20 probably would challenge that more. But, I suppose 15:49
21 that's some of the learning personally for me.
22 273 Q. Did that approach change over time? You mentioned when
23 you were new you were told phone ahead, sometimes I
24 think probably for practical reasons but over time as
25 the staff got to know you and your colleague and what 15:49
26 OTs did a bit better, did you find them less likely to
27 say phone ahead or you can't come now or how did that
28 go?
29 A. From memory that did continue that we had to continue

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1 to phone ahead and if there was any distress on the
2 ward they would have advised us not to come.
3 274 Q. And were you able to make any inroads in terms of
4 helping interventions for patients who were showing
5 signs of distress or do you feel that was something 15:49
6 that the wards kept you out of?
7 A. It would have been quite difficult for us because if we
8 are only seeing them when they are calm and regulated
9 and we are not seeing what the cause of the distress
10 may have been, what it might look like, whether we 15:50
11 could have intervened at the time. Now we would have
12 seen much less distress on the resettlement wards. The
13 OT that I supervised would have covered more the
14 assessment and treatment ward and there would have been
15 much higher levels of, I suppose, distress on those 15:50
16 wards. And I think she was eventually able to make
17 some inroads that she would have seen some episodes of
18 distress. And for us, as I say, that is useful and for
19 her, as far as I can remember, she would have had I
20 suppose more training in relation to safety 15:50
21 intervention so that she could obviously keep herself
22 safe. So I think over time -- but again I am speaking
23 on behalf of someone else now -- I think it did maybe
24 change a bit.
25 275 Q. Okay, thank you. Shelley, those are all my questions 15:51
26 but I am conscious the Panel may have some questions
27 for you, so I am going to hand over to the Panel just
28 now and perhaps the camera could be turned around so
29 you can see?

1 CHAIRPERSON: Professor Murphy on my right.
2
3 DR. CRAWFORD QUESTIONED BY PROFESSOR MURPHY:
4
5 15:51
6 276 Q. PROFESSOR MURPHY: I wanted to ask you a bit about
7 resettlement wards, you mentioned them in paragraph 11
8 and named them, was it your impression that patients
9 had been moved into those wards because they were going
10 to be resettled? 15:51
11 A. I'm not sure of where they would have been throughout
12 their time in Muckamore. I know that some of them had
13 been in Muckamore for a long, long, long time. My
14 impression with the likes of Greenan and Rathmullan
15 ward were that those patients had been on those wards 15:52
16 for quite a long time. So I don't know that they were
17 moved there specifically for resettlement. I got the
18 impression that, and I could be wrong, that Rathmullan
19 would have been a ward for individuals that maybe had a
20 presentation more of a physical disability and Greenan 15:52
21 ward would have been the same, it would have been
22 patients who were female whose presentation would have
23 been more of a physical disability. So I did get the
24 impression they had been on those wards for a long,
25 long time. 15:52
26 277 Q. But the very fact that they were called resettlement
27 wards, it kind of implies that everybody there was
28 about to be resettled. Was that your impression, was
29 that what you were told, that everybody in these wards

1 was about to be resettled?
2 A. That's what we were told, that everybody, unless they
3 were in the assessment and treatment wards, was to be
4 resettled.
5 278 Q. And the assessment and treatment wards like Cranfield 15:53
6 for example, that your colleague covered, am I
7 understanding you right that there had never been any
8 OT in those wards either?
9 A. Yeah, that's right.
10 279 Q. Okay. And did you cover, from the OT point of view, 15:53
11 all of the patients in those wards or did you receive a
12 specific referral, person X, please would you assess
13 their resettlement needs, or were you just
14 automatically covering all of the patients in those
15 resettlement wards, for example? 15:53
16 A. No, we would have responded to referrals.
17 280 Q. Right, okay. Then I had just one other question for
18 you, you were talking later on about how the nursing
19 staff were sometimes a bit sceptical about resettlement
20 but that you gradually convinced them after you 15:54
21 described how well people were doing, did they ever get
22 the chance to go out and visit people who had been
23 resettled, did they ever get the chance to go and see
24 them themselves?
25 A. I don't think so, but I couldn't be sure if they did or 15:54
26 they didn't, but for the most part not so much.
27 281 Q. Okay, thank you.
28
29 DR. CRAWFORD QUESTIONED BY DR. MAXWELL:

1
2 282 Q. DR. MAXWELL: Hi, when you were responding to Ms. Tang
3 I think you said, and correct me if I'm wrong, that you
4 worked there until 2015 when the resettlement team
5 ended, did you say that or have I misheard that? 15:55
6 A. Sorry, say that again?
7 283 Q. Did you say that you worked in Muckamore until 2015
8 when the resettlement team ended?
9 A. No, I think there was a target I think at a time that
10 resettlement had to be complete by 2015 but they kept 15:55
11 changing every year, the target kept being missed. So
12 I think the post continued on after myself and my
13 colleagues left, there is now other people, other OTs
14 in those posts.
15 284 Q. So did you leave because your secondment had ended or 15:55
16 did you leave because you chose to apply for another
17 job?
18 A. I chose to apply for another job.
19 285 Q. Okay, so since you started there has continuously been
20 OTs as part of a resettlement team, as far as you know 15:55
21 up to today?
22 A. As far as I know, yeah.
23 286 Q. Okay. I want to ask you a little bit about record
24 keeping because you've talked very eloquently about the
25 very specialised skills of an occupational therapist 15:56
26 and you are there as part of the resettlement team.
27 Where did you record your assessments?
28 A. We would have had our own occupational therapy
29 assessments and we would have kept them in our files.

1 As far as I can recall we would have put copies of the
2 postural assessment in the -- or any other reports and
3 stuff, we would have shared them with our nursing
4 colleagues and I think we would have put them in the
5 nursing notes. 15:56
6 287 Q. Okay, so you would have done your own professional
7 notes and would you have kept them in separate
8 occupational therapy files?
9 A. Yes.
10 288 Q. Okay, thank you for clarifying that. 15:56
11 A. Sometimes if there was anything of note, from memory I
12 think we would have put a note in the nursing notes as
13 well.
14 289 Q. Yes, but the full assessment would be in your
15 professional files? 15:57
16 A. Yes.
17 290 Q. Thank you.
18
19 DR. CRAWFORD QUESTIONED BY THE CHAIRMAN:
20 15:57
21 291 Q. CHAIRPERSON: Can I just pick up on that, you would
22 keep your OT notes. If you went to an MDT about a
23 patient, particularly about resettlement, would you
24 take those notes with you?
25 A. We probably would take the file with us, yes. 15:57
26 292 Q. And if you were asked for them would you be able to
27 make them available to other professional colleagues?
28 A. During the time that we were in Muckamore the system
29 changed so the notes went on PARIS so that meant that

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1 all professionals could read each other's notes.
2 293 Q. Do you know when PARIS was started at Muckamore? Can
3 you remember when that was? I'm sure we'll find out
4 through the Trust but I just wondered if you --
5 A. I can't recall the exact date but we were originally 15:58
6 doing written files and then it moved to PARIS notes
7 now there would have --
8 294 Q. So sorry, go on, I didn't mean to interrupt you?
9 A. Sometimes you can't put everything on PARIS so we would
10 have retained minimal paper files where we would have 15:58
11 kept maybe assessments that you purchased through
12 Pearsons and things that you would fill out and put in
13 the file and then reference in your PARIS notes, so
14 there would always have been information that would
15 have been in your professional file and would you 15:58
16 reference it on PARIS.
17 295 Q. With PARIS or without, so even before PARIS, if your OT
18 assessment was relevant to the needs of the client
19 post-discharge, would other professionals be able to
20 ask you for them? 15:59
21 A. They would, yes, and usually we would have done a
22 discharge summary or a report on each individual
23 outlining what, from an OT point of view, we believed
24 their assessed need to be.
25 296 Q. Yeah, quite. We've heard, this is nothing to do with 15:59
26 your evidence, but we've heard a bit about a sort of
27 change of the nature or culture of the hospital around
28 2010, 2012. And in your statement you say, and Dr.
29 Maxwell I think has just -- in fact both my colleagues

1 have picked up on this, that there were no OTs there
2 for approximately 30 years prior to your appointment.
3 Do you mean the whole of MAH, there were no OTs?
4 A. That's correct, there was no OT service provided.
5 297 Q. Did that surprise you? 16:00
6 A. It did, given the level of need of the patients that we
7 would have been involved with.
8 298 Q. But once you started in 2000, in fact it was the end of
9 2012, December 2012, there has been a constant OT
10 presence since then as far as you know? 16:00
11 A. As far as I am aware, yeah.
12 299 Q. Again I just had a difficulty about timing, you were
13 there, was it, if we go to your paragraph 33, I think
14 the punctuation might have gone wrong but it might not
15 have done. You say: "You left MAH after a few weeks 16:00
16 when I returned from maternity leave in 2015." I don't
17 quite understand that sentence. When did you leave
18 MAH?
19 A. September 2015. So I came back from maternity leave
20 and worked a week or two, but I had already handed in 16:01
21 my notice and got another job while I was on maternity.
22 300 Q. I see and how long were you away from MAH on maternity
23 leave?
24 A. 12 months.
25 301 Q. Right. So in fact, although you were on the books, you 16:01
26 were physically present from December 2012 to around
27 December 2014?
28 A. That's right.
29 302 Q. Right, okay. And in paragraph six, you say this was,

1 you talk about access to specialised wheelchair
2 training and you say:
3
4 "This was because across the region OTs would provide
5 this type of assessment and equipment with the 16:02
6 exception of MAH."
7
8 So again it wasn't the absence of OTs, there was also
9 no specialised equipment as far as you knew for the
10 clients at MAH until you turned up in December 2012? 16:02
11 A. Yeah, I suppose because the OTs would have the
12 specialised seating budget. If there is no OTs there,
13 the service users aren't likely to get access to that.
14 303 Q. And did you, when you arrived, did you have any contact
15 with the management at MAH to inquire as to why there 16:02
16 had been no OT service until your arrival?
17 A. I don't know why that was the case. I know that I
18 think there was somebody in the PHA and my manager was
19 very keen and we were having conversations with the
20 managers at Muckamore to say, you know, there is a real 16:03
21 need for OTs within that service, particularly around
22 the resettlement piece, around the environment, the
23 housing. So I think it was acknowledged that there was
24 a lack of OT, but why it had never been invested in, I
25 can't answer that, I don't know the reason for that. 16:03
26 304 Q. Actually if it weren't for resettlement, the
27 resettlement process taking place, again it may be you
28 can't comment, but it doesn't sound as if OTs would
29 have come into Muckamore at all because you were really

1 brought in to help with resettlement, is that right?
2 A. That's right, it was really the resettlement post that
3 created the additional post.
4 305 Q. And then finally this, paragraph 36, well 35 and 36,
5 you talk about the culture needing to change and you 16:04
6 give some examples, for instance getting patients or
7 clients ready for life outside Muckamore, about
8 shopping as an activity and cooking as an activity.
9 But the two examples you give, it doesn't sound as if
10 the staff member was actively engaging with the client 16:04
11 to teach them how to shop or teach them how to cook.
12 Is that a fair summary of that part of your evidence?
13 A. Yeah, I think they thought they were because when we
14 came to came to the independent living programmes and
15 would have went and spoke to the staff beforehand, they 16:04
16 would say 'he could do that' but then when we stood
17 back and seen that he actually couldn't do it. So I
18 suppose there is a difference in being involved in an
19 activity than actually breaking the activity down so
20 that the individual can do it and actively engage in 16:05
21 it. So they would have been involved in it but maybe
22 not reaching their maximum potential to be independent
23 or to do that activity with minimal support.
24 306 Q. And some places I think, I don't know about this
25 jurisdiction, but have for instance practice kitchens 16:05
26 where an OT can take a patient to practice pretending
27 to cook or actually practice cooking or practice
28 shopping. Have you come across that yourself?
29 A. Yeah, a lot of facilities that OTs would work in would

1 have that, yes. In Muckamore, in the likes of
2 Oldstone, because those wards were homes, they were
3 actual houses, there was a large kitchen dining area
4 and we would have utilised that to be able to do that.
5 Within the day centre as well, I remember being 16:06
6 involved with some, I suppose, independent living
7 programs because there was a nice space over there with
8 an assessment kitchen and things that we were able to
9 utilise.
10 307 Q. You as OTs could use that? 16:06
11 A. We could use that.
12 308 Q. Were you aware of the staff using it to teach patients
13 or not?
14 A. I'm not sure of others, how well it was utilised, I
15 don't know. 16:06
16 CHAIRPERSON: No, okay. That's me done I think. My
17 two colleagues are finished and counsel is finished.
18
19 So, Dr. Crawford, can I thank you very much for, not
20 coming to assist us, but leaving your workplace, you 16:06
21 are still in uniform so I can imagine you are still
22 working in fact. But can I thank you for taking a good
23 couple of hours to assist us and for your statement
24 which has been very open and has also opened our eyes
25 to the world of OTs. I think you are the first OT 16:07
26 we've heard in the Inquiry and it has been very useful
27 to find out what you do and how you can assist
28 patients, so can I thank you very much for your
29 attendance okay.

1 A. Thank you.
2 CHAIRPERSON: Thank you. All right.
3 MS. TANG: Thank you very much, Shelley.
4 CHAIRPERSON: We can switch off the feed. Tomorrow at
5 10 o'clock? 16:07
6 MS. TANG: Tomorrow at 10 o'clock, the evidence of
7 Phillip Ward and Ms. Bergin will be taking the witness
8 through his evidence.
9
10 THE INQUIRY ADJOURNED UNTIL 10.00 ON WEDNESDAY, 15TH 16:07
11 NOVEMBER 2023
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