MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY 26TH SEPTEMBER 2023 - DAY 61

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

GWEN MALONE STENOGRAPHY SERVICES

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THE INQUIRY RESUMED ON TUESDAY, 26TH SEPTEMBER 2023, AS FOLLOWS:

CHAIRPERSON: Good morning. Yes, Mr. McEvoy, I gather we've got problems with our first witness this morning. 09:59

MR. McEVOY: It was anticipated that P8's mother would give evidence orally, but she is unavoidably unavailable this morning, so it's proposed that I read the statement in.

CHAIRPERSON: I gather she's unwell. And just to mention, I think the same may apply to the witness on 28th, Thursday, in the afternoon, but we'll see where that goes. We are giving witnesses the opportunity to join by Zoom if they're able to do so. Okay. But in the meantime, we're going to hear you read P8's mother? 09:59

MR. McEVOY: That's right. And the Inquiry reference then is statement no. 147. The statement is dated 6th of September 2023.

STATEMENT FROM P8'S MOTHER READ: 10:00

MR. McEVOY: "I, P8's mother, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. In exhibiting any documents, I will number my documents. So my first document will be exhibit 1." 10:00

And, Panel, there are a number of exhibits that I propose just to draw your attention to at the

conclusion of the statement.

"My connection with Muckamore is that my son P8 was a patient in Muckamore. The relevant time periods that I can speak about are from 3rd June 2011 to 6th October 2017, when my son was discharged from Muckamore. 10:00

My son P8 was born on 8th December 1990. He is now 33 years old. He has three siblings" – who are named – "born on 6th April 1999, born on 18th May 2000, and then a third who was born on 6th June 2001 and unfortunately died on the same day. 10:00

P8 was my first born and he was delivered in the Mater Hospital in Belfast. I had a normal pregnancy, but P8 had a forceps delivery. P8 was a good wee boy. He slept and fed well. When P8 was born, I moved in with my mum and dad for support. My mum and dad helped me a lot when P8 was baby, as did my sister." 10:01

10:01

P8 father's is named.

"However, he was parented by me and my former husband" – who is also named – "who I married in August 1994.

10:01

P8 was a bubbly and active child. P8 had a passion for any type of music. He loved car keys and playing with cushions. He loved his food. He was a happy child and was pleasant to be around. I took him to mother and

baby group activities at various places where we lived. P8 attended nursery" – in a town which is named – "for one year in September 1995.

I recall when P8 was five years old, in and around June 1998, we lived in" – and she names the location – "my sister and I were going to a darts competition. It was a Tuesday evening. My sister was driving and she pulled the car over and told me that she had something that she needed to say to me. I thought she was going to tell me that she was ill or something like that, but she told me that our neighbour" – who is named – "told her that two boys had been playing in the field beside our house and the two boys had touched P8's penis. The two boys were aged nine and ten and P8 was five years old at the time. I was told that the matter had been reported to Social Services and that a social worker was coming out to my house to tell me about this incident and investigate the following Thursday. The two boys had been sexually abused by their daddy and had a history of touching other young boys. 10:02 10:02 10:02 10:03

On the Wednesday prior to the meeting with the social worker on the Thursday, it was arranged to meet me at my sister's house. I was told that her two boys told her that they had touched P8 down below on his private bits. I did not want to hear what she was telling me, but I told her that I did not blame her for what her boys had done. I could not believe that this had happened to my son. 10:03

On the following day, two social workers came out to my house. I recall that one of them was named... of Social Services. I do not recall the name of the other social worker. The social workers advised me that P8 had touched two boys, which was not what that other person had told me the previous day. 10:03

I recall taking P8 to Social Services offices during the summer of 1996 so that he could be interviewed about the incident. There was a chalk table in front of him in the room. A girl was interviewing him about the incident. I do not recall her name. P8 just kept drawing red circles on the chalk table around and around with the chalk. 10:03 10:04

Due to the age of P8 and the circumstances that there were conflicting views of what occurred, nothing further was done in respect of the incident.

10:04

After this incident, P8 drastically changed. It was like a light switch. He became withdrawn. He soiled his clothes with urine and bowel movements frequently. He just wanted to sit watching television all of the time. He became jumpy and nasty. His attitude changed and he became very clingy to me and would not let me out of his sight. In turn, I was afraid to let P8 out of my sight after what had happened to him. 10:04

P8 went to primary one in September 1996. This is a mainstream school."

His teacher is then named, his primary one teacher is then named. 10:04

"I recall she had just completed a course in children's special needs. She advised all of the parents on the first day that she would be arranging meetings with each of them after the Halloween break. She had 10:05
arranged a meeting with me. However, within two weeks of P8 starting in the school, the teacher advised me that P8 was hiding under the table and trying to lock himself into broom cupboards. The teacher reminded me that P8 should be assessed by the Education Board as 10:05
potentially having special educational needs.

The assessment did not take place until P8 went into primary two."

10:05

The teacher, the primary two teacher is then named. A lady is then named from the Education Board, who came out to assess P8 at his school.

"I do not recall her surname or her job description. I 10:05
recall that she was assessing six other children at the same time. After the assessment, the school principal and this lady invited me to a meeting at the school and advised me that they thought that P8 had attention

deficit hyperactivity disorder. The person from the education authority was recommending that P8 take a table" – which presumably should read "tablet" – "which she described which would be like a sedative and he should take half of a tablet at bedtime and half of a tablet in the morning. I do not recall the name of the medication she was referring to. I was unhappy about this and refused, as P8 was only six years old. Eventually, this lady called P8 diagnosed with P8 having severe behavioural needs. I am sure that I received something in writing confirming this, but I do not have a copy of it. I do not recall exactly when this was. 10:06 10:06

I continually contacted P8's general practitioners about him soiling himself." 10:06

The doctor is then named.

"He arranged an appointment with a doctor at another health centre" – which is named – "He specialised in behaviour and incontinence. This was in and around 1996. He advised me that he believed that P8 had an overactive or lazy bowel. The doctor believed it was also a behavioural problem. 10:06 10:07

P8 regularly came home from school covered in urine and excrement. I had to keep sending in changes of clothes for him. He would urinate or make a bowel movement and

then just sit in his clothes. I kept trying to retrain him to use the toilet.

P8 refused to communicate with me or his teachers. He would pull his jumper up over his head or go under the table when we tried to talk to him. 10:07

P8 did not progress to primary three at that mainstream primary school. He could not cope with the school. He went to another school. This was educational behaviour unit. I recall that he was collected in a taxi at 7 a.m./7:15 a.m. and did not return home until 4:30 p.m. or 4:45 p.m. each school day. He was exhausted and in bed before 6:30 p.m. He was there for around six months. 10:07

I recall he was allowed to return to school for one day to make his First Holy Communion with the other children. P8 got on okay at school, but there was no change in his behaviour. 10:08

When P8 was seven or eight years old, he went to a behavioural unit at a primary school" – in a town which is named – "He attended there for one year, but I recall he was asked to leave, as he had hit out at a teacher. I do not recall the teacher's name or any other details of him being asked to leave the school. Thereafter, P8 was home schooled, as I was advised by the employee from the education authority that there 10:08

was nowhere else for him to go. Someone from the education authority came out to our house a few hours per day, three days per week to teach him. I cannot recall the name of the teacher.

10:08

Thereafter, he attended a special school" – in a place which is named – "This was a brilliant school. He attended there until he was 19 years old. The staff there knew how to handle P8's behaviour. When he was ten or eleven years old he also attended another place for respite. He attended that place once per month from Wednesday to Friday and the staff left him off and collected him from school whilst on respite.

10:08

P8 was put on to Children's Disability Social Services at the Trust by his general practitioner."

10:09

And the social worker is also named.

"The doctor and the social worker were married to each other. P8 really clicked with the social worker and they had a good relationship. P8 did not like males, but he had no issue with females. A social worker attended our house for visits to see how P8 was getting on and also linked in with P8's school.

10:09

10:09

When P8 was around 13 years old, there was an incident in my friend's house. P8 was playing with her daughter" – who is named – "who hit P8 on the back with

a stick. There was a bruise on P8's back and when P8 went into school, one of the teachers in the school noticed the bruise. P8 told the school that I had hit him and there was an investigation. I recall going to the general practitioners and the doctor advised me that P8 would not be allowed to come home with me that evening. I recall my sister had to take P8 overnight while they investigated the incident which led to the bruise. P8 was allowed to come home with me again the next day. 10:10

P8's behaviour and needs were monitored by his general practitioner and social worker. I recall being advised by a doctor and social worker that P8 should be admitted to a behavioural unit for assessment." 10:10

And the place, the location of the place is named.

"I agreed to this, as they told me that P8 would still attend school. He did attend school for a little while after admission, but they stopped taking him to school, as I was advised that P8 had stopped communicating. I recall that he was in that location for a few months. 10:10

I recall that it was P8's birthday and I had asked the hospital if I could take him out for the day. There was a miscommunication between the hospital and I and when I returned to the hospital with P8 after our day out, the hospital would not let me leave him back in 10:10

again. The they discharged him and he came home with me. P8 returned to the school again. I cannot remember any other details about this or staff involved."

10:11

I don't propose, Panel, to read the next paragraph, because it deals with an unrelated set of allegations and I don't think it adds anything to the Inquiry's work for me to read them out. But I will pick it up at paragraph 19:

10:11

"When P8 finished school at 19 years old, which was in June 2010, he had no interest in anything. Local activities were organised by Gateway, but P8 did not want to participate. He stayed at home with me and my husband."

10:11

And the next paragraph, the beginning of the next paragraph to the bottom of page 7 deals with the circumstances of an index incident and I don't propose to read it out, Chair, but I can summarise it. Suffice to say, it leads to an investigation. And then if I bring it up at the bottom, the very bottom of the page, the third line from the bottom:

10:12

10:12

"We instructed a firm of solicitors" - who are named - "The social worker from the Adult Disability Team at a hospital" - who is named - "was P8's social worker at the time. He advised me that I should put P8 into

Muckamore for an assessment as a voluntary patient, as he suggested that this may assist him in respect of the ongoing court case. He advised me that P8 would only be in Muckamore for six to eight weeks. He advised that if I did not put him in voluntarily then the court would put him in. 10:12

P8 went into Muckamore on 3rd June 2011 and was admitted to Six Mile Assessment. H52 was the nurse in charge who dealt with the admission. I recall P8 was very upset and he was crying. I phoned three or four times per day in the first few weeks, but P8 refused to talk to me. He also refused to see me. 10:13

P8 was in Muckamore and the court case was still running. When the six to eight weeks was completed, I had a meeting with H50, the consultant, and H92, the ward social worker at Muckamore. They advised me that they did not understand why I was under the impression that P8 would be in Muckamore for only six to eight weeks. 10:13 10:13

After this meeting, matters went down hill quite rapidly. I kept asking for information regarding P8 and his treatment, but I never received any satisfactory answers. I spoke to whoever nurses were on at the time. H13 was the ward manager and H14 was the forensic nurse. I asked or applied to the ward multidisciplinary team on several occasions for P8 to 10:13

be given home leave, only to be responded to with excuses as to why P8 was not permitted home. I would be advised, usually by either H13 or H14, that P8 was not complying with requests from staff.

10:14

From the date that P8 entered Muckamore, I was given limited information about him and his treatment. I have a power of attorney for P8 and I am his next of kin. I was never properly informed of anything to do with P8 by any staff at Muckamore. I never got to see 10:14
where P8 slept or ate. It was P8 that kept me informed during our conversations and visits. The staff told me very little. For example, in the first year P8 was in Muckamore, he had a few health issues that I was not informed about until P8 told me weeks afterwards. P8 10:14
told me that he had bloods taken and that his bloods were too high. I do not know what this meant. P8 told me that there was something wrong with his liver. I recall P8 asked me if he was going to die, but I could not answer him, because I knew nothing about this. He 10:15
told me he had been to the dentist and had a filling two weeks after he had had the appointment. I found out that P8 had been to the opticians only when he came out to me during one of my visits wearing a pair of glasses. P8 told me that he had a toenail removed by 10:15
the pediatrist. I do not recall the specific dates of any of these events, but they were during his first year in Muckamore.

I issued a letter of complaint to Mr. Patrick Convery, Mental Health and Learning Disability Team at RQIA by letter dated 16th August 2012 listing these and other complaints. I attach a copy of the letter at Exhibit 1. These may appear as small things, but they were of great importance to me as P8's mother, as, up until he went into Muckamore, I had accompanied my son to all of his health appointments since he was born. I felt that Muckamore was withholding important information about my son's health from me. 10:15

On 9th March 2012 the Crown Court in Northern Ireland made a Sexual Offences Prevention Order stating that P8 was under a disability."

10:16

I don't propose to go into the details of the order, which is exhibited to the statement.

"On the same day, 9th March 2012, H50 applied for, and was granted, a hospital order to detain my son for further treatment. I was not provided with any notice of the application or the reasons why he was to be detained, or indeed the treatment H50 said my son needed. I do not have a copy of the hospital order. 10:16

10:16

When P8 was in Muckamore, I kept pushing for him to be allowed home visits. It was requested by H92, social worker, through Family Social Services that I was to have an assessment done at home. This assessment was

called Prevention to Protect. This was successfully completed by me, the results of which were supposed to be sent to Muckamore on 13th March 2012. I tried on numerous occasions to find out if these results were sent or received, but this was to no avail and Muckamore insisted that they had not received them. I spoke with H258, H50 and H14 all separately about it. 10:17

On 6th July 2012 I was told these results were in fact sent and received by Muckamore on 6th June 2012. For four weeks, Muckamore had these results but still had continued to tell me that they had not received them. I felt that Muckamore was trying to hinder me from getting my son released by putting barriers up to stop me getting day release for my son, due to saying that the results had not been received. H92 and H14 had told me on occasion that my son could not have day release due to serious adult protection concerns. 10:17

On 12th April 2012 I made a verbal formal complaint to H13, the ward manager of Six Mile Assessment about three staff members harassing my son, being H506, H367 and H381. My son had advised me that H506 regularly said to him things like 'filth like you should not be given any luxuries.' P8 told me that he was reading the paper one day and H506 said to him that he was staring at photographs of children, which P8 advised me was not true. P8 advised me that H506 snapped the paper from him and he was punished by not being allowed 10:17 10:18

to go to the Cosy Corner shop. P8 advised me that H381 always complained about P8 for nothing. I requested that those three staff members would be kept away from my son. However, this did not happen. It did not feel that my complaint was taken seriously by H13, as I did not receive any feedback from him. 10:18

On 19th June 2012 an allegation was made against my son by one of the other patients on Six Mile Assessment. That patient worked with P8 in the gardens of Muckamore. Initially, I did not receive details of what the allegation was. 10:19

On 22nd June 2012 P8 was put on Level 3 supervision or observation due to the allegation. H92 and H50 allowed my son to phone me to tell me that he had been put on to Level 3. He rang me in a very distressed state. I was very annoyed about this, as I felt I should have been contacted by a staff member to advise me of this instead of my distressed son. P8 was due to be given day release from Muckamore on 23rd June 2012, which was cancelled due to this allegation. And he was also due to be attending horse riding, which was also cancelled. P8 was also prevented from completing two group sessions of his treatment with the Good Progress group. I was annoyed about this, because the sessions were taking place in Muckamore and a member of staff could have accompanied him to the sessions, as he was on Level 3 supervision or observation, which I understand 10:19 10:19 10:20

means that P8 had to be in eyesight of a member of staff.

I recall me and my family attended Muckamore on 23rd June 2012 as P8's day released been cancelled and when I arrived at Muckamore for the visit I was advised by H14 that I had to spend our visit in one of the visitors rooms with a member of staff sitting in with us. We were not permitted to take P8 to the Cosy Corner, which was the on-site cafe at Muckamore. We were herded like cattle into a small visitors room and treated like criminals. We were not allowed to open the window, the blinds or the door. We were advised by H505, one of the Assistant Staff Nurses who attended P8 at our visit, that this was necessary as we were not allowed to make eye to eye contact with the person who had made the allegation against P8 or his family. I still did not know what the allegation was at this time. The room was very stuffy and there were about nine people in it. The room was very hot. We could not have a private conversation with P8, as H505 was present at all times. 10:20 10:20 10:20 10:21

During this visit, H505 did not leave the room without P8 accompanying them, which is not what Muckamore's policies and procedures state as a Level 3. Level 3 means that a staff member needs to be one to one eyesight. Level 4 is within arm's length. I was unhappy that Level 4 observation was being subjected on 10:21

P8 during our visit when this was not the level of supervision that P8 was imposed.

I recall that having staff sitting in on our visit made us, as a family, feel uncomfortable and an invasion of our privacy. It also made P8 very upset. I asked to speak to H77 to complain, but was told by H505 that he was not available. I had spoken to H517, a Staff Nurse, on the morning of 23rd June 2012 before attending for the visit and at no time did he advise me that these restrictions would be imposed on our visit. The distress caused to P8 as a result of being put on Level 3 observation concerned me gravely. 10:21 10:22

I complained to H507 on 25th June 2012 by telephone about the visit. I do not know H507's job title, but she was a very senior person in Muckamore. She was very abrupt with me on the telephone. She disagreed with what I was saying and what had occurred during the visit that I was complaining about. I felt that our discussion was unnecessarily very heated and she was unprofessional with me. She was very tense with me on the telephone. She did not have a satisfactory response for me. I followed this up with a letter to H77 on 10th July 2012. I received a response from H508, Complaints Administrative Officer at the Belfast Trust, by letter dated 11th July 2012 advising me that my complaints be investigated. I attach copies of these letters at Exhibits 3 and 4 respectively. 10:22 10:22 10:23

During the course of the first year that P8 was in Muckamore, he advised me that another patient pushed him onto the ground outside in the garden. He told me that staff members tried to make out that he had fallen over a plant pot. My son is not stupid and knows what really happened to him. His injuries were a badly cut and scored knee, cut and scored hand and a cut and scored elbow. I cannot recall any further details around this. 10:23

P8 advised me on another occasion - I cannot recall when this was - that a different patient was going to attack him over a sandwich. P8 advised me that he had ordered a sandwich for his lunch and when the sandwich arrived, the other patient told P8 that the sandwich belonged to him. When P8 advised him that the sandwich belonged to him, P8 and the other patient quarrelled. P8 advised me that this patient had intimidated him on several occasions and P8 was afraid of him. 10:24

In my letter to Mr. Convery of RQIA on 16th August 2012, I also raised a number of additional serious concerns." 10:24

Which are described. And I think what I'll do is I'll take it up at the start of the next page. But they concern various matters not involving the staff and patient abuse, needless to say. But the witness then

says at the top of page 13:

"I did not feel that this was a safe environment for my son to be in. I was seriously concerned that my son needed out of the ward before someone hurt him or something bad happened to him.

I recall on 8th July 2012 I telephoned P8 in the evening and he was very distressed. He advised me that H14 had called him into the ward office for a 'wee chat'. H14 told my son that he was called in because he was messing about with a staff member's pass on 6th July 2012. P8 advised me that H14 proceeded to state that my son was in Muckamore for a very serious crime and went on to state that the crime was rape. My son was not in Muckamore for this reason. P8 also advised me that H14 brought up the subject of my complaint about staff harassing him which I had made to H13. P8 advised me that H14 told P8 'your mum can't help you while you're in here.'

10:25

10:25

10:25

10:25

I begged in my letter to request that Mr. Convery should conduct a thorough investigation into the issues that I raised. I also urged Mr. Convery to assist me in having my son released home to me.

10:26

I was so distraught at this time that I wrote to Dr. Michael Maguire, the Police Ombudsman for Northern Ireland, Margaret Ritchie, MP for South Down, at the

House of Commons, Edwin Poots MLA, Minister for Health, Social Services and Public Safety, the Secretary of State and the Minister of State for Northern Ireland. I received acknowledgments of my letters, most of which fobbed me off, advising that it was a devolved matter and I needed to deal with the Belfast Health and Social Care Trust. I do not have copies of all of the letters that I issued, but I have attached copies of the letters which I have and copies of the responses that I received at Exhibits 5 to 10 attached. 10:26

My sister and I attended a meeting at Muckamore on 23rd January 2013. The meeting was attended by H287, the Service Manager, and H77, Assistant Service Manager. I put some direct questions to H287 and H77, mainly concerning the fact that my son remained on Level 3 observation despite the fact that the police had decided not to prosecute in respect of the allegation which had been made against him by the other patient on 19th June 2012. My sister prepared minutes of the meeting, where she recorded the exact responses to my questions. We asked H77 to sign the minutes at the end of the meeting, but he refused. The outcome of the meeting was that H77 advised that I needed to speak to the multidisciplinary team. I attach copies of the minutes of the meeting prepared by my sister at Exhibit 11. 10:27

I sent a letter of complaint to the Belfast Trust on

16th August 2012 complaining of the same issues contained in my letters at paragraph 30 of my statement. I do not have a copy of the letter, however I did receive a response from H287 by letter dated 31st January 2013. The letter advised me that I needed to speak to H50. I attach a copy of the letter dated 31st January 2013 at Exhibit 12. 10:28

On 26th November 2012 I wrote a letter to H50 asking for day release for P8 over the Christmas and New Year period. I do not have a copy of this letter. I was advised by telephone that this was refused. I cannot recall who advised me of this, but it was a staff member at Muckamore. I asked for this to be followed up with a written response, which it was, by letter from H50 on 27th February 2013. I was advised that my request was refused due to a continued concern of the multidisciplinary team regarding P8's behaviour. I was very annoyed not to have P8 at home, even for a brief time, over this Christmas period. I attached a copy of the letter from H50 dated 27th February 2013 at Exhibit 13. 10:28 10:28 10:29

I had absolutely no confidence or trust in the majority of staff on Six Mile Assessment or Six Mile Treatment, including the multidisciplinary team. The staff in Muckamore kept putting P8's release back, but I was not getting answers as to why this was happening. I strongly believe that my son was being wrongly treated 10:29

by staff and the multidisciplinary team at Muckamore. I felt that if something happened to my son in Muckamore that it was rarely, if ever recorded, but anything that he was accused of was recorded straightaway. I think he was victimised in Muckamore. 10:29

Life on the ward was very stressful for P8 and I did fear that there was no prospect of him getting proper treatment or ever being released. My son's life was in the hands of professionals. I thought Muckamore could 10:30 treat my child and return him to some form of normality, but instead he was treated like a prisoner.

I believe that certain staff, namely H506, H367 and H381 were picking on my son to get him to react so that 10:30 his release could be delayed. H50, who was the consultant in charge of my son's treatment, had never been upfront or open with me and certainly did not keep me informed. I would go so far as to say that he was very deceitful. H50 constantly refused to take my 10:30 calls and he hid behind medical jargon and would not explain anything to me as regards what was going on with P8's treatment in Muckamore. He was like a politician. I asked him one question and he answered with the information that he wanted me to receive, not 10:31 an answer to my question. In my view, H50 done absolutely nothing to help my son. All that he did was put hurdle after hurdle up to prevent my son getting home, where he belonged and I knew he would be safe.

Not all staff were bad, however. H518, one of the nurses in Muckamore, was very good with P8. H67 and H516 were also good with him.

10:31

I tried desperately hard to get my son out of Muckamore as soon as I possibly could. During the Mental Health Review Tribunals where P8's continued detention was reviewed, I engaged lawyers and barristers to appear to push to have him released. He was refused release at a hearing on 12th April 2013. H50 issued a written report dated 31st March 2015 which made a recommendation that P8's detention be released with restrictions. I attach a copy of the report at Exhibit 16.

10:31

10:32

None of the staff in Muckamore advised me of the advocacy service available to patients and families offered by Bryson House. I only became aware of this by speaking with another patient's mother in the Cosy Corner at some stage during 2016. I reached out to Bryson House for an advocate to assist and support me with the various tribunal hearings and generally with my dealings with Muckamore. I was assigned an advocate" – who is named – "but I never knew his surname. He helped me get documents released from Muckamore to assist me and my legal team to deal with the Tribunal hearings. I believe he helped me eventually to get P8 home.

10:32

10:32

At a Tribunal hearing on 12th August 2015, following an adjournment of a hearing on 15th April 2015, the Tribunal stated that P8 could be released, with restrictions which needed to be accommodated by the Belfast Trust in advance. I attach copies of correspondence received from the Mental Health Review Tribunal, Northern Ireland Courts and Tribunal Service confirming the outcome of these various hearings at Exhibits 14, 15, 17 and 18. 10:33

I was eventually given a release date for P8, to be on 6th June 2017. However, he was not released on this day. P8 was due to be released into supported living, but P8 wanted to come home and live with me. Muckamore were putting pressure on me to find suitable accommodation for P8 to live, given the terms of the court order dated 9th March 2012, which were, and still remains, in place. Eventually, P8 was released home to live with me on 6th October 2017. 10:33

Since P8 was discharged from Muckamore, he flourished. He mows the lawns and cleans the cars of our neighbours. He is learning to drive. He is very good at home and looks after me. He has put Muckamore behind him and he continues to spend time with H518, a former nurse from Muckamore, and her husband. P8 loves animals and listening to music. P8's time in Muckamore were the worst six years of my life. P8 continues to 10:34

be subject to a court order, where he could be recalled to Muckamore at any time. There is no end date on the court order. He has to report to the police and Social Services once per year. I have recently been making inquiries with the Police Service of Northern Ireland to see whether the court order can be lifted or amended, given that it has been in place now for over 11 years."

That is the end of the substance of the statement. The Panel will obviously have read the entirety of the statement and the exhibits. It's the view of your counsel team that you may want to consider the exhibit at number 10, which is on page 41, which is the response from the RQIA to the complaint letter that P8's mother described and which is at Exhibit 1.

CHAIRPERSON: Sorry, page 41?

MR. McEVOY: This is page 41. So this is a letter dated 20th August 2012, Chair. And it's a letter, essentially, of acknowledgment. And you can see that it's from the then Director of Mental Health, Learning Disability and Social Work, who at that time was Theresa Nixon. She has CC'd in the then Chief Executive of the South Eastern Trust. We don't have, in the exhibits, the outcome or the followup, the consequence in other words, of that and it's something that the Panel may wish to follow up in due course.

CHAIRPERSON: This refers back to the letter which is at our page 35?

MR. McEVOY: That's right. So this is the letter of acknowledgment to the complaint letter.
CHAIRPERSON: Yes.
MR. McEVOY: The original letter to the RQIA, just for reference, begins on page 23. It was addressed to Mr. Convery, but this response comes from Ms. Nixon. So we don't have an outcome to that and we don't know what happened, certainly in terms of the specific issues raised by P8's mother. So it's something that the Panel may wish, in due course, to follow up. 10:36

The other item of possible note was the written response. It may be that there isn't a great deal of significance attaching to this, but there was, in the statement, the application for Christmas leave for P8 which was turned down by telephone call, the witness told us. Written reasons for that follow up at Exhibit 13 on pages 46 and 47, but they're dated 27th February and... 10:37
CHAIRPERSON: Yes. 10:37
MR. McEVOY: There's no specific -- there are five signatories to the letter, but there is no specific reason for the lapse in time.
CHAIRPERSON: Which is three months after the letter.
MR. McEVOY: Yeah, and considerably after Christmas 2012. That's something you may wish to examine further. 10:37

And then there is, if I could also draw your attention

then to the exhibit which begins at page 58 and runs through to 63, which the Panel will recall is the report from H50 to the Mental Health Review Tribunal about P8. It is, as far as your counsel team can recall, one of very few such examples and certainly the clearest example of such a report that we've seen during the witness experience and it may be that the Panel considers that it wants to follow up questions about the methodology - maybe not at this stage, obviously, in the Inquiry's work, but perhaps later about the methodology that's followed in completing these reports, whether by H50 in particular or others, or and/or others. 10:38 10:38

We don't have the other reports that are referred to in the first paragraph, the witness has not exhibited those, but presumably if the Panel considers it necessary, those are items that we can certainly follow up. 10:39

And then finally, we have the decision that the witness described, which begins at page 65. And in substance then, the final decision around discharge begins at page 68 and that's the final statement of reasons where the Mental Health Review Tribunal sets out why it has found P8 fit for release, or certainly not to be detained any longer at Muckamore. And it may be -- again this is the first clear cut example of such a statement of reasons that a patient experience witness 10:39

has produced to you and it may be that the Panel consider it necessary to get a feel or a more rounded picture of how these decisions are produced and indeed how Muckamore staff play their particular role in this process. Had the witness been able to attend this morning, that's something certainly I would've asked her to recall for us. 10:40

So unless there's anything further, those are the issues that... 10:40

CHAIRPERSON: No, there was one minor thing that I picked up on. At paragraph 26 of the statement the witness refers to an incident when she attended a meeting with her son.

MR. McEVOY: Yes. 10:41

CHAIRPERSON: And she complains that they were herded into a small visitors room and there were about nine people in the room. And just out of interest, at page 24 of the exhibits there's a reference to the same meeting, where she refers to seven people in the room. 10:41 So that may not matter, but she may be slightly inaccurate about that.

MR. McEVOY: Yeah.

CHAIRPERSON: All right. Well, thank you very much indeed. I gather the witness has not actually been watching, but we will convey our thanks in writing to the witness of that statement. 10:41

So far as this afternoon is concerned, I gather that

the witnesses can be here at 1:30. And so if everybody can be available, we'll try and start slightly early this afternoon, so if people could be available from 1:30 onwards, we'll start as soon as the witnesses are ready. Okay, thank you very much indeed. 10:42

THE HEARING ADJOURNED FOR A SHORT TIME

THE INQUIRY RESUMED AS FOLLOWS

CHAIRPERSON: Thank you very much. Okay, let's get the witnesses. Are both witnesses coming in at the same time? 13:59

MS. KILEY: They are, but one will sit with the secretary, because the witnesses are also accompanied by a Family Liaison Officer who will sit with each of them whenever they are at the table.

CHAIRPERSON: Right, thank you. 13:59

MS. KILEY: It's Family Liaison SW2, who is known to the Inquiry.

CHAIRPERSON: Yes, I've seen him this morning. And there are no hearing problems?

MS. KILEY: No. 13:59

CHAIRPERSON: Excellent.

P113'S MOTHER, HAVING BEEN SWORN, WAS DIRECTLY EXAMINED BY MS. KILEY AS FOLLOWS:

14:00

CHAIRPERSON: Good afternoon. Can I just welcome you to the Inquiry. We met very briefly in that room at the back. Thank you for making a statement, thank you for coming with your husband to come and assist us. We know that you want to refer to your son as P113 and 14:00 that's going to be fine. And I think you've heard that I've made an order that that name can't be used or published outside of this room in relation to the evidence that you give. So, feel safe, as it were,

using the name when you want to, all right?

A. Thank you.

CHAIRPERSON: Thank you very much. I'll hand you over to Ms. Kiley.

1 Q. MS. KILEY: Good afternoon. You are P113's mum and that's how you'll be known this afternoon. And we met briefly earlier on and I explained the process of giving evidence. So just to do introductions, sitting beside you is your Family Liaison Officer, isn't that right? And he is already known to the Inquiry as Family Liaison SW2, so if you hear that, that's who we're referring to. And sitting on your other side is P113's dad. And P113's dad is going to be giving his own evidence later on this afternoon, okay? But it's your turn first, P113's mum. 14:01

You have made a statement to the Inquiry and I see you have a copy of that in front of you. So the first thing that I have to do is read portions of that out. As you know, there are portions that are subject to a Restriction Order, so I'm not going to deal with those, okay? So if I skip over those, that's why. And we will return to those in our later closed session, okay? You'll also hear me, whenever I'm reading out the statement, not use some names, but instead refer to cipher numbers. And you have a list in front of you there if you want to check who I'm referring to, okay? So if you are ready, I'll start reading. Are you ready P113's mum? 14:02

A. Yes.

2 Q. Your statement is dated the 6th of September 2023 and you say this:

"I, P113's mum, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry. In exhibiting any documents, I will number the documents, so my first document will be Exhibit 1. Family Liaison Officer SW2 attended with me when making my statement. 14:02

My connection with MAH is that I am a relative of a patient who is at MAH. I wish to keep the names of my family members private, so when I refer to them I will only state the nature of their relationship to my son. 14:02

The relevant time period that I can speak about is between 13th of April 2017 to the date of my statement. 14:03

My son P113 was admitted to MAH on 13th April 2017 when he was 20 years old. P113 is the middle child of three sons. He was born." 14:03

And you give his date of birth. And you say:

"In and around 1999 and 2000, I don't know the specific date, P113 was diagnosed with a severe learning disability, autism, inversion chromosome 3 and a tic disorder. P113 has limited vocabulary. He can say hello and ask how are you, but he cannot tell me when 14:03

he needs something or if something is wrong. If P113 is in pain, he will say that he has a sore head or sore tooth, but the pain maybe somewhere else. P113 has a high pain threshold. For example, he lost the tip of his finger in a gardening accident when he was seven years old and he did not cry or respond to the pain. 14:04

I understand P113 and know when he needs something by the way he behaves. P113 finds it difficult to adapt to change in his environment and becomes very distressed. When P113 is stressed or is asked to do something that he does not want to do, he demonstrates self-harm. He has cauliflower ear because of hitting his head with his fists. He bites his hand, throws things and sometimes strips naked. He grabs people by the hair in a firm grip and will not let go. One time he grabbed me by the hand so hard that I thought it was broken. P113 does not know his own strength. 14:04

I will provide background information about P113's difficulties and the events that led to him being admitted to MAH on 13 April 2017. 14:04

Following P113's diagnosis, he was accepted to school in September 2000. He was four years old." 14:05

And you name a school that provides education for children with special needs until they reach 19.

"P113 was to remain at that school until he was 19 years old. In 2012, when P113 was 17 years old, his behaviour began to escalate. He often became angry and he expressed this by hitting staff and his classmates."

14:05

And you then, for the remainder of that paragraph and through to paragraph 7, explain the difficulties that P113 had in school in more detail. The Panel has seen all that and I won't read all of that aloud.

14:05

At paragraph 7 then, again to summarise, you say that P113 was admitted as an in-patient to the Iveagh Centre on 1st December 2014 and he was discharged on 25th December 2014 because he turned 18 on 26th December 2014, so he couldn't stay there any longer. 14:05

To pick up the reading then at paragraph 8, you say:

"Following his discharge from the Iveagh Centre, the school put a plan in place that allowed P113 to return 14:06 to school on a reduced and phased return basis."

And you then tell us a little bit more about how that worked in practice. And again to summarise paragraphs nine to eleven, you describe the continued difficulties 14:06 which P113 experienced at school and then at day centre and respite and the challenges that he continued to experience there.

I'll pick up the reading at paragraph 11 then, where you say:

"The time leading up to P113's admission to MAH was difficult. P113 was not sleeping and often woke at five o'clock in the morning. When P113 wakes, either P113's dad or I have to wake with him, as he cannot be left unsupervised, because he may hurt himself.

The weekend of 8th/9th April 2017, just before P113 was admitted to MAH, was extremely difficult at home. P113 was acting out, as something had triggered him. He was screaming and throwing things. In his frustration, P113 threw a lamp with a brass candlestick attached that hit me on the back of my head. P113's dad and I tried to calm P113, but we could not. I was extremely distressed and felt helpless, so I telephoned the regional emergency social work service helpline to speak with a social worker. I was told someone would call me back. A social worker called me back around 20 minutes later and told me to ring P113's general practitioner. When P113 acts like this, there is no benefit in calling his general practitioner, as he does not have specialist knowledge about the drugs that P113 has been prescribed to manage his behaviours, so he could not help. A doctor" – who you name and say who was based in MAH – "was P113's doctor at the time. When she met P113, he was usually calm and she did not witness him during the periods where he was acting and

hitting out. As there was no support offered by the social worker other than the recommendation to contact his general practitioner, we had to deal with this experience on our own.

14:08

On Monday, 11th April 2017, I brought P113 to the adult day centre. He was still demonstrating aggressive behaviour. I told staff in the adult day centre what happened over the weekend. They contacted SW11, social worker at the Northern Health and Social Care Trust, who arranged for P113 to stay in a respite centre for emergency respite. P113 stayed in the emergency respite centre overnight on 12th April 2017. The next day, 13th April 2017, I received a phone call from a member of staff at the respite centre. I do not remember who called me. I do not remember being told exactly what happened, but I was aware that P113 was in the dining area when he took his clothes off and hit out at staff. I was told that P113 was to be admitted to MAH and brought there by ambulance and handcuffed to a police officer. They told me to meet P113 at MAH. I was very distressed, so I cannot recall exactly what I did after the phone call, but I remember calling P113's father at work and said that he needed to come home. I went home and began to pack some clothes and items for P113. P113's father met me at home and we travelled to MAH together. I was in a state of shock that P113 was to be admitted to MAH, so I do not clearly remember the

14:08 14:08 14:09 14:09

journey there.

When P113's father and I arrived at MAH, I remember it was the evening time. I spoke to a member of staff. I cannot recall who they were or what they looked like. 14:09
I do remember we were in the reception area leading to a visitors room. I was so upset about what was happening that I cannot recall many details about the day that P113 was admitted to MAH. I remember a member of staff told me that P113 was taken to the assessment 14:10
ward in the Psychiatric Intensive Care Unit (PICU) and it was best that we did not see him until he was assessed. P113 was detained under the Mental Health (Northern Ireland) Order 1986.

14:10

I remember a staff member from the respite centre" – who you name – "brought some of P113's personal belongings to MAH. We brought some belongings for him too. A social worker, I cannot recall their name, and a member of staff from MAH, I do not know who it was, 14:10
told P113's father and me that we could not see P113, as he was being assessed and that we should give him time to settle in MAH.

I telephoned MAH the next day for an update on how P113 14:11
was doing. I do not remember with whom I spoke. They confirmed that P113 remained in PICU and had settled. I do not remember if they told me if he was given any medication. I asked if I could visit P113 and was told

to wait a few days to allow staff to finalise their assessments and allow him to settle in PICU.

I am not sure exactly when P113's father and I first visited P113 after he was admitted to MAH, but I think it may have been around one week later. I rang every day to find out how he was and asked when we could see him. I remember on our first visit we met with P113 in the visitor room. I remember that PICU was a secure unit with one big room. I could see into the unit through the glass panel. When we visited, P113's staff took us into the visitor room. I was told what I could not visit P113 in his bedroom, as this was not permitted in the interests of visitor and patient safety. 14:11 14:11 14:12

I remember a staff member told me that P113 liked a room that had glass in it. When P113 was in PICU, I only seen his room once, as he was refusing to shower for the staff. Nothing particularly stood out to me about his room, as my concern was to wash and dress P113. 14:12

On the first visit to PICU, P113's father and I were asked to complete a questionnaire setting out what P113 liked and did not like and what might trigger him. This was the first of many requests to complete this questionnaire. When P113 moved to Cranfield 1 and Cranfield 2, we were asked to complete the same 14:12

questionnaire. I queried why the information provided on the questionnaire was not available from P113's records and was told not all staff had permission to access patient records on the system, so staff required us to complete the questionnaire when the authorised member of staff was not working. I cannot recall who told me this. 14:12

When P113 was admitted to PICU he was under the care of a Band 4 Staff Nurse called H89. I went to school with H89, so I took comfort in knowing that she was caring for P113. I remember after a visit H89 walked me to my car and told me that P113 was doing fine and he was settling well in PICU. 14:13

On another visit at the end of April 2017 H89 told me that P113 was to leave PICU and move to Cranfield 1, as a young man was to be admitted and needed the bed. She said that it was good that P113's father and I were with P113 when he moved to Cranfield 1. This was around the end of April 2017. P113's father and I walked P113 from PICU to Cranfield 1 along with staff members who brought P113's belongings. I do not know who they were. As we walked to Cranfield 1, P113 linked on to his father and me and told us that he wanted to go home. We tried to reassure him that he would be okay and that the doctors were going to make him better. A member of staff showed us to P113's room. We walked through the ward to get to P113's room 14:13 14:13

and I was told there were 14 beds on the ward. I remember thinking that Cranfield 1 was a busy place compared to PICU and there were many staff working on it. At this time I did not take much notice of the surroundings, as settling P113 into his new room was my priority. P113 had his own room with a television.

I visited P113 three times a week in Cranfield 1. On Wednesdays I visited him on my own as I was off work. On Fridays and Sundays of each week I visited with P113's father. On Fridays we took P113 to Junction One or to Ballymena. We did not take him home for some time. We discussed home visits with staff, but we were encouraged not to take him home until MAH had an opportunity to settle P113 on the prescribed medication. 14:14

Usually on Wednesday I took P113 out for a walk and we would go to the Cosy cafe on MAH grounds. If I needed to go somewhere outside of MAH, I took P113 with me, for example to Abbey Centre in Newtonabbey. 14:15

There were times when P113's dad and I visited P113 in Cranfield 1 to take him out for the day and found that he was not shaved or dressed. We were told by staff that he refused to allow them to help him get ready. On these occasions, P113's father and I agreed with staff that if P113 did not want to shave or dress when they asked, that we would get him ready, as this was 14:15

less stressful for P113 and also helped staff. There was one occasion when I visited P113 and was told that he was in his pyjamas for the whole day as he refused to change. This was unusual for P113, so I decided to take him home for the night to clean him and change his clothing. 14:15

P113 is reluctant to eat with others, as he likes his own space. P113 finds changes overwhelming and needs time to transition. When P113 was first admitted to Cranfield 1, he sat in the communal dining room with other residents. When eating, P113 requires his own space, with minimal noise, so he did not cope well sitting in the communal dining area. P113 refused to eat and expressed himself by throwing his food on the floor. I do not know how often this happened, as there may have been times when staff did not tell me. The only reason I found when P113 had not eaten his dinner is that I asked if he had when I telephoned MAH every day for an update. Staff did not tell me voluntarily. I was concerned that P113 was hungry, especially as he loves food. I was told that he would be given toast or something light to eat. I cannot recall whom I spoke to about this, but it was another staff member on the ward. 14:16 14:16 14:16 14:16

P113 lost weight when he was in PICU and Cranfield. He refused to stand on the weighing scales for staff, but I could see that he lost weight, as his clothes were

looser on him. Eventually I was able to convince P113 to stand on scales to weigh him and it showed that he had lost weight. I think he lost a few kilos. After a few weeks he was allocated a room where he could eat alone. I remember there was a big window in the room from which P113 could see the nurses' station. As P113 seemed to enjoy sole use of the room, H67, who was a Band 5 nurse, who was then promoted to Deputy Ward Manager, helped set up the room for P113 to use daily by adding a sofa and television so that he could sit there rather than in the communal areas. 14:17 14:17

When I telephoned MAH or asked for updates when visiting P113 in Cranfield 1, I found that they could not tell me a lot of information about P113's day. For example, as I was aware that PRN medication had previously been administered to P113, I wanted to know if and when this was done and the reasons. On one occasion I asked a member of staff, I cannot recall their name or description or the date, for details and was told that only senior members of staff had access to the computer system with P113's record on it and they would pass on my query. Sometimes someone from MAH followed up and sometimes they did not. 14:17 14:18 14:18

When P113's father and I visited P113, we usually took him out of MAH for the day. We expected him to be ready to go outside when we arrived, subject to him complying with staff requests, as agreed with them.

There were times when he was in Cranfield 1 and Cranfield 2 we found him wearing tattered pyjama bottoms and he would not be dressed and ready to leave MAH. When this happened, I took P113 to his room and dressed him. I do not understand why P113 was wearing tattered pyjamas, as I regularly buy him new pyjamas. 14:18

There were issues with P113's clothes going missing in MAH. When I buy P113's clothes, they are sent to the laundry in MAH to be labelled. I put the clothes in a carrier bag and put a label on it with P113's name and a note to say that the clothes needed to be labelled. His grandmother brought P113 a new Adidas top that cost £45 and we noticed on a visit six months later that another resident was wearing it. This also happened to a top that one of P113's brothers gave to him. One day when we visited P113, we saw a resident who was much larger than him wearing his top. Some other clothes disappeared without explanation. When I raised these issues with H67 in MAH, I was told that staff did not know that the pyjamas and top were for P113 and they were labelled for another patient. I was also told that when clothes were sent to the laundry, sometimes they were returned to different wards. This is what they say every time clothing goes missing. As P113's pyjamas were new, H67 agreed that MAH would replace them. 14:19 14:19 14:19

I take some of P113's clothes home and wash them to

prevent them from being lost. If we buy P113 expensive clothing, we keep them for him to wear when he is with us. For example, we keep his winter coat in the car and put it on him before he leaves MAH and we take it home when we leave P113 back to MAH. 14:20

There are times when P113 goes through a phase of not wanting to wash and refuses to change his clothes when he was in Cranfield 1. Even so, I expect staff who were caring for him to make sure that he is clean. 14:20
P113 requires time to adapt when he is asked to do something that is not within his regular routine and staff in MAH are aware of this, as I have told them. There were times when I visited P113 and found him sitting in soiled clothing. When I asked staff why 14:20
P113 was sitting in soiled clothing, they told me that they tried and that P113 refused and lashed out. On these occasions, I washed P113. Sometimes staff offered to help, but I prefer to look after him myself on these visits. 14:21

P113's bedding in Cranfield 1 was, and continues to be, of poor quality. His duvet is lumpy and very thin and I do not believe that it keeps him warm. When his duvet is washed, all the polyester bunches up at one 14:21
side. When it is put back on his bed, it has not been smoothed out and does not fit to the corners of the duvet cover. I bought him warm throws for his bed to keep him warm. MAH provide one pillow for P113 to

sleep on that is very flat, so I have repeatedly asked staff to give him two supportive pillows to sleep on. When I complain about the quality of the bedding, staff tell me that duvets and pillows are laundered so much that they can not provide fresh bedding regularly. 14:21
When I suggest I bring in a duvet and pillows, I am told that I cannot, as they have to be fire retardant. I recall that I bought P113 a pillow and wrote his name on it with a laundry pen, but it disappeared. When I asked staff where it was, I was told that it was sent 14:22
to the laundry and might have gone to Cranfield 2 and they would check, but it never returned. This occurs regularly.

I remember meeting with H93, social worker with Belfast 14:22
Trust, when P113 was in Cranfield 1 during a multidisciplinary meeting in MAH. H93 suggested that it might be possible for P113 to come home. I told H93 that there was no day care or respite support available. I said that nothing had changed with P113's 14:22
behaviour and I cannot possibly take him home. This is the reason that P113 is in MAH. I cried, as I was so upset. I told him P113's father and I exhausted all the options open to us. The school did not look after P113. The adult centre tried to help and adapt their 14:22
services for P113. Ultimately, no care facility would accept P113 on a long term basis.

At the time, H93 suggested we could take P113 home I

had not been provided with a progress report setting out what improvements they had seen in P113 since his admission to MAH. I am aware that the team thought P113 settled with medication, however I did not believe this to be true. There were times when we visited that P113 seemed to be heavily medicated. He was in a trancelike state and lacked energy. I believed that during these times staff had administered PRN to P113 to calm him, meaning medication is given as required. I wanted to know when this was administered to him and asked staff when I visited. I wanted to know if PRN had been administered. I only spoke to H93 at these meetings. There was very little contact with him outside of these meetings. 14:23 14:23

P113 stayed in Cranfield 1 for approximately six to eight weeks. He was then moved to Cranfield 2. P113 settled relatively well to Cranfield 1 and I do not know why he was moved to Cranfield 2. I remember noticing that the layout in Cranfield 2 was similar to Cranfield 1. P113 had his own bathroom and living area. There was a pool table in the room and when I asked why the pool table was in the room, I was told that it would be removed. 14:24 14:24

P113 did not settle in Cranfield 2. I am aware that staff in Cranfield 2 tried a number of medications to see if they would help him. I knew by P113's behaviour that he did not settle in Cranfield 2. For example, he

wet himself. I was told that he tried to jump over the nurses station. During his time in Cranfield 2, P113 told me that he wanted to go back to PICU, but I do not know why.

As P113 could not settle in Cranfield 2, he moved back to PICU for approximately seven weeks in November 2017. I remember that he was in PICU on his 21st birthday. P113's father, brothers and I visited him on the PICU ward and brought balloons, cake and presents to celebrate. We met P113 in a small room outside the ward and took some photographs with him. His brothers only stayed a short while in the room, as P113 can become unsettled around them, so they waited in the visitors lobby. During this visit, a member of staff from PICU said that P113 would be moved to Cranfield 1 in the new year. 14:24 14:25 14:25

There were times when P113's father and I visited him that we were not allowed to enter MAH, as there was an incident, but we were never told we could not see P113. A staff member would bring him out to us and we would sit at the window or stand at the door so P113 could see us and come out. 14:25 14:25

Before P113 was admitted to MAH, P113's father and I met with SW11, who told us that a new facility."

which you name, and then say:

"Gordon Lyons MLA was assisting us in these discussions and continued to do so when P113 was in MAH. Although P113 was admitted to MAH, there was still a plan to move him to a residential care home. P113's father and I met with the resettlement team that included H186, who was the resettlement officer with the Northern Trust, a team from MAH, a team from the Belfast Trust and staff from MAH. They discussed P113's needs and what the residential care home could do to support him. As the residential care home were due to be the service provider, they met with P113 to carry out a visual assessment and reviewed his notes. Following the assessment, a meeting was set up in early 2017 with the resettlement team in MAH, which I attended by myself as P113's father was working. It was at this meeting that the residential care home told me what they could not accept P113, as they were unable to meet his needs. I was shocked when I heard this, as I was not expecting them to announce the decision on that day or to say no. I remember speaking to H186 after the meeting and she told me that she was not aware that the residential care home reached a decision and that they would announce it at the meeting.

14:26
14:26
14:26
14:27
14:27

I believe that when P113 was first admitted to MAH that I was naive about the level of care that could be given to him. No one forming part of P113's multidisciplinary team managed my expectations by

setting out the limitations of the treatment in MAH. There was no discussion about the assessment process and I was only aware of a lot of information, for example, about P113's care at the MDT meetings.

14:27

Glynn, who is the father of a patient at MAH and who had requested to see the CCTV footage from PICU made me aware of the allegations against members of staff in MAH in late summer of 2017. Glynn and his wife visited their son on similar days to P113's father and I and we 14:28
often spoke to each other. On the day he told me about the allegations, I met him in the car park. He did not provide a lot of information, but said what his son had been abused in MAH.

14:28

Not long after I became aware of the allegations of abuse, I remember one Friday when P113's father and I were getting P113 ready to take him out for the day a nurse called H457 came into his bedroom. I cannot recall her surname. H457 was crying and she looked at 14:28
P113's father and said she was sorry about everything. At this stage, we were not aware that P113 was involved, so I remember P113's father and me saying to each other that it was an odd thing for H457 to say. We put it down to her having a bad day, or perhaps she 14:28
was stressed as the press were reporting on the abuse claims. In hindsight, I wonder if she may have known that P113 had been mistreated and that we would eventually find out.

I can clearly recall the day that I was told P113 was a victim of abuse from staff on PICU. It was a Friday in May 2018 and I had taken P113 to the Tower Centre in Ballymena. We were walking through the centre and P113 was linking me as we walked. I missed a call from an unknown number and picked up a voicemail from H283, social worker of safeguarding with Belfast Trust. I remember saying to P113's father that something must have happened to P113 at MAH. I did not return the call as I could not speak privately. I received a further call from H283 when we were walking through the centre. She told me she was reviewing CCTV footage as part of the investigation into allegations of abuse against staff at MAH and that she could see from the footage that P113 was involved in one or two incidents. I felt completely numb and sick. I told her I could not speak to her, as I was in the shopping centre. I think I said to her that I would like to meet to discuss what she said. I did not want to talk about the incidents when I was with P113, as he knows if something is wrong by the tone of my voice and I did not want to upset him. I was upset that she told me what happened to P113 over the telephone, as I think she should have told me in person, especially as I visit P113 three days a week in MAH. Furthermore, staff at MAH were aware that P113 was with me at the time and I feel that this should have been considered before ringing me and upsetting our family time

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together.

Following the call from H283, P113's father and I met with H411, Safeguarding Manager with the Belfast Trust, on 8th June 2018. As Gordon Lyons MLA was supporting our family in trying to move P113 out of MAH, we asked him to attend the meeting with us. We met with H411 in the administration building at MAH. She refused to allow Gordon Lyons into the meeting, as she told us that Belfast Trust required written consent from P113's father and I that had to be approved in advance by senior management. She said that there were criminal investigations ongoing and that the information discussed was confidential. P113's father and I confirmed we consented to Gordon Lyons attending the meeting and discussing P113's medical records. However, H411 would not accept this as consent, as consent was not provided in writing. Gordon Lyons was not permitted to attend the meeting, so P113's father and I met with H411 without him.

In preparation for the meeting with H411, I wrote out questions that I wanted to ask her. I wanted to know what happened to P113 and who was responsible. I also wanted to tell her how I felt about the way in which I was told about the incidents on the telephone. H411 began the meeting by explaining her role and that she would answer any questions that she could. She said that she had information to give us about adult

safeguarding and the PSNI investigation. She acknowledged that the investigation was frustrating for parents and carers, as only limited information could be provided, as they did not want to jeopardise the PSNI investigations. 14:32

I told H411 about the call I received from H283 and that I thought she was very unprofessional to tell me when I was not at home and did not have privacy to speak to her. I said that a telephone call is not a good way to break such bad news to parents. Staff at MAH knew that I visited P113 three days a week, so they could have told me in person or arranged to meet there. She said she was not aware of this. H411 said that making telephone calls to report incidents to carers was 'never easy' but she accepted how I felt. She said that they try to avoid reporting incidents on a Friday afternoon as they do not want to upset people over the weekend, when there would be no-one available to speak with them. 14:32 14:33 14:33

I do not think she understood how upset I was by the call. She told me that along with H283 and H49, Senior Social Worker for Safeguarding with Belfast Trust, they were reviewing the CCTV footage. She told us that the investigation was bigger than anticipated and that Belfast Trust were recruiting additional people to review it, including retired staff. I do not know if recruitment was limited to Belfast Trust or if other 14:33

Trusts were involved."

Moving then to paragraph 33, you start with "she", and by "she" you mean H411.

14:34

"H411 told us that she had worked as a social worker for 35 years and was passionate about people. She said that she did not want staff to wriggle out of anything. She said 99% of the staff in MAH were excellent. She said that H283 and H499 were to speak to the MAH staff involved in the incidents to relay that the behaviour seen on CCTV footage was not acceptable. We were not advised of the names of staff involved. We were told that unannounced safeguarding checks were to be carried out on the wards."

14:34

14:34

Then picking up at paragraph 36, you say:

"As P113's care and social worker fell under the remit of the Northern Trust, I asked H411 if the team were aware of the incidents involving P113. P113's father and I were aware of three incidents at the time of the meeting and I told her that I did not want P113 to stay in MAH. She told me that the CCTV footage was reviewed by the Belfast Trust and that Northern Trust was not involved in the investigation process, but they are aware that P113 was the subject of some incidents.

14:34

14:35

I found that H411 did not answer my questions at the

meeting. I said to her at the end of the meeting that I did not believe that she told us anything confidential that Gordon Lyons MLA could not have heard. As the meeting was coming to an end, she said 'out of every bad situation comes good'. I do not know what she meant by this, but I found it very insensitive. I felt that she was implying that good things came out of my son being abused. I disagree. I left the meeting very upset after what she said." 14:35

Then I'm going to pick up the reading at paragraph 40. You say:

"Belfast Trust invited family members and carers of patients who were still in MAH to a meeting on 24th November 2018. The meeting was held in the Portland Building at MAH. Only four or five families attended. The meeting was arranged to discuss a report published following a safeguarding review after the allegations of abuse were made. The report is called "A Review of the Safeguarding at Muckamore Abbey Hospital - A Way to Go". A copy of the report is enclosed at Exhibit 2. 14:36 14:36

The report was prepared by a Review Team, who found that 'people with learning disabilities should not have to live at Muckamore Abbey Hospital and that the management and practitioner skills and efforts required to effect modest change on patients lives are better spent in creating high quality community services.' 14:36

Margaret Flynn was the Chair of the Review Team. One member of the Review Team that I remember in particular" – who you name – "was a parent of a disabled adult son. Her son was not a patient or former patient of MAH. She told us about her son and how she managed him so that he was able to stay at home. She said that she would never send her son to MAH. I felt this comment was inappropriate. She did not know our circumstances and how we exhausted all of our options to keep P113 at home. His admission to MAH was out of our control, as we did not voluntarily admit P113 to MAH. We wanted P113 to leave MAH from the day he was admitted and tried to resettle him in the community, without success. I thought what she said was thoughtless and insensitive. However, the other members of the Review Team were very professional. 14:36 14:37 14:37

When the meeting ended, I spoke to Marie Heaney, Director of Adult Social and Primary Services within the Belfast Trust. I told her that I found the meeting overwhelming and that it was difficult for me to take in what the Review Team said. I told her that P113's admission to MAH was a last resort, as respite could not care for his challenging behaviours, all day care facilities we had previously used could no longer take him and our family had horrendous time with P113 before he was admitted to MAH, we were at our wits end. She offered to meet me another time to discuss my concerns. 14:37 14:37

I attended a meeting with Marie Heaney in the administration building at MAH on 11th December 2018. I cannot recall how the meeting with Marie Heaney was arranged. I met with her by myself. I think that the Assistant Director in the Belfast Trust was also there. Marie apologised on behalf of the Belfast Trust and acknowledged that it failed the loved ones of patients at MAH. She assured me that Belfast Trust are taking the allegations and investigation very seriously. She told me that staff were to be offered further training and senior management would carry out safeguarding spot checks at any time during the day and night. I said to her that I did not take comfort from this, as I believed safeguarding checks were already in place and they did not uncover the abuse that took place, so she could not guarantee that P113 would not be subject to abuse again. Marie Heaney told me there were plans to secure more care providers so that people like P113 who are still in MAH could leave and live in the community with all the support that they required. She told me that disabilities in Northern Ireland, particularly autism, were growing and forward planning to meet assisted living needs was required. 14:38 14:38 14:38 14:39 14:39

Following the meeting, I received a letter from Marie Heaney dated 20th December 2018. A copy of the letter is enclosed at Exhibit 3. The letter provides an overview of what we discussed and offered psychological

services to my family.

In May 2018 P113's father and I attended a resettlement meeting with the multidisciplinary team at MAH, who were implementing a two year resettlement plan. It was 14:39
proposed that P113 would move to a residential unit. The plan to place P113 in the residential unit came following the residential unit's assessment and was proposed by H186, Resettlement Co-Ordinator. She invited P113's father and me to walk around a bungalow 14:40
that was being renovated that maybe suitable for P113. It was proposed that P113 would live with one other male resident. After seeing the bungalow, I was so happy that P113 would be moving out of MAH into his own home. 14:40

I attended a number of meetings to discuss the resettlement plan with the MDT. I attended those meetings on my own, as P113's father was working. A lot of people attended the meetings to discuss the 14:40
multidisciplinary assessments of P113's needs. The team included a consultant psychiatrist, I cannot recall their name; H500, Resettlement Community Nurse for Learning Disability; H67, Staff Nurse from Cranfield 1; H259, Resettlement Social Worker; H501 14:40
from MAH behavioural services; and H193, occupational therapist.

I remember saying during one meeting that there were

too many people in the room for me to understand what they were saying. Everyone in that room was aware of how complex P113's needs were and the care and support needed to ensure his move to the residential unit was a success. 14:41

The resettlement team in MAH managed P113's resettlement to the residential unit. H299, who is a Community Integration Project Co-Ordinator in MAH and part of the resettlement team, arranged for P113 to attend with a doctor" – who you name – "consultant psychiatrist with Belfast Trust, who assessed P113's capacity to provide his consent to proposed restrictions for placement at the residential unit. The proposed restrictions included no access to his finances, being given medication on a PRN basis when agitated, having limited access to kitchen areas because of the presence of dangerous equipment, having one to one staffing, having toiletries and razors locked away, having a door alarm on his bedroom. The doctor examined P113 and found that he did not understand the information provided and he lacked capacity to give informed consent due to his intellectual impairment. A copy of the report dated 19th March 2019 is included at Exhibit 4. 14:41 14:41 14:42 14:42

A welfare report for best interests considered was prepared by H259, who was P113's social worker with the Adult Learning Resettlement Team employed by the

Northern Trust based in Magherafelt Community Services Centre. Her report notes P113 is 'considered a vulnerable adult and is at risk of potential exploitation.'

14:42

The report details the proposed community care plan. Two staff members were to provide P113 with care 24 hours a day and support him with his personal care. P113 was assessed as no longer requiring hospital input and, therefore, a community placement is required to meet P113's needs to maintain him safely within the community. P113 is currently a delayed discharge patient. A copy of H259's report is attached at Exhibit 5.

14:42

14:43

There was a delay in moving P113 to the residential unit, as there were not enough staff to care for his needs 24 hours a day, as required under his care plan. I was aware that the residential unit was under the management of."

14:43

A person who you name. And you say the manager worked in the Kingscourt Residential Home in Templepatrick, which was behind the residential unit and they're all under the umbrella of Manor Healthcare.

14:43

"When the residential unit purchased the bungalow, the manager was to manage it. I remember that the residential unit regularly advertised job vacancies and

had difficulty securing staff. The bungalow was unfurnished, so before P113 moved in, P113's father and I purchased a sofa, chairs and bed for him. On 25th September 2019, P113 moved into the bungalow at the residential unit. 14:44

It was agreed by the Belfast Trust, the Northern Trust, the residential unit and MAH that P113 was to remain listed as a patient in MAH and was not to be discharged until he was settled in the residential unit. 14:44

As part of the care package to ensure the transition from MAH to the residential unit went as smoothly as possible, staff at MAH were to support Manor Healthcare to show them how to care for P113's needs to help him 14:44 settle in the new environment. I recall being told by the manager of the residential unit that it was best if MAH staff stopped attending with P113, as he became unsettled when they left. 14:44

After approximately three weeks, I received a telephone call when I was at work from a lady from Manor Healthcare. I cannot be sure of her name, but I believe she was a senior manager. She told me that P113 threatened to hit another resident, so he had to 14:44 leave. She contacted MAH to say the placement had not worked out and P113 was to be admitted again to MAH. P113's father and I collected P113 from the residential unit to bring him to MAH. We parked at the back of the

bungalow and entered through the back door."

And you name some staff who met P113's father and you, along with a female nurse from MAH, who again you name. And you say: 14:45

"The owners of Manor Healthcare were also there. P113 was sitting in the living room in a daze and looked remorseful, which is common after he acts out. The Manor Healthcare representative told me that the final straw came when P113 threatened hit the other resident. She asked P113's father and myself if we wanted to speak to the owners, who were in another room, as it was their decision to remove P113 from the residential unit. 14:45

The Muckamore staff member said she would take P113 back to MAH, but I said that P113's father and I would take him back. My priority was to remove P113 from the residential unit and bring him back to MAH. I began to 14:46 pack up P113's clothes and belongings, as I brought a holdall. The manager gave me plastic bin liners and offered to help me. I refused, as I was very annoyed. We went into the living room, where the owners were sitting and one said that there was no chance of them 14:46 changing their mind. He was very blunt and rude. He said the decision had been made and the relevant people contacted.

P113's father sat with P113 whilst I was packing his things. We took P113 to MAH, where he went back to his room in Cranfield 1. I believe the reason P113's stay in the residential unit was not successful was due to the lack of staff training to care for P113's complex needs." 14:46

Then I'm going to move on and pick up the reading at paragraph 55, which is at page 30, if you have that. And you say there: 14:47

"After I found out about the incidents involving P113, I was invited to meet H183, Assistant Director of the Northern Trust and the adult safeguarding specialist within the Northern Trust, who were both based in Holywell Hospital, Antrim. I met with them in Holywell Hospital on my own. I cannot recall the date of the meeting. They did not discuss the abuse investigations, but tried to reassure me that P113 would be resettled in the community. I told them how I felt about P113 being in MAH since I found out about the abuse and how I do not want him to stay in there any more. I am concerned that P113 will become too institutionalised and this may lead to him being unable to settle in the community. I told them that I want the resettlement to progress so that P113 can start a new chapter. They told me they had two years to resettle the remaining patients in MAH and they would do their best to find P113 the right place to live. 14:47 14:47 14:47

P113 remains in Cranfield 1 today. He still has his own room. I have always worried about P113's welfare and safety. Now that I am aware that P113 was abused in MAH, I worry even more. I expressed my concerns to H498, Safeguarding Social Worker in the Belfast Trust, who is responsible for safeguarding in MAH and she agreed that staff would report any incidents involving P113. 14:48

I also want to know when PRN has been administered, especially if it is given to him when he is due to come home, as this effects how P113 feels during his stay. PRN is supposed to be used as a last resort and I am concerned what PRN is used as a calming method rather than assessing that P113 needs it. When P113 has been prescribed PRN, he is very tired and lethargic. I can see it in his eyes when he is heavily medicated. His mouth falls open, causing dribble to flow down his chin and on his clothes. When the medication wears off, he is cranky, like someone with a hangover. This is not normal for P113. 14:48 14:49

Despite my requests to be told when PRN is administered, I am still not informed when it happens. I have to ask staff, which makes me feel uncomfortable, as I am only ever given a short and what I feel is often a dismissive reply that they would come back to me. I feel that I should be told what medication they 14:49

are giving my son. I do not know when the last time P113 got PRN was.

P113 was at home just before Christmas in 2022 when I noticed that he had a bump on his head and bruising on his arms. I asked H498 what happened. She contacted me by text message on 3rd January 2023, advising that an incident occurred on 16th December 2022 where P113 had repeatedly banged his head on fire doors and chased staff. PRN was provided and medical level 3 handholds, three minutes sitting was used as restraint. The notes record that P113's father picked P113 up at 11:30 p.m. She also reported the use of PRN on 21st of December 2022. A copy of her text message is marked Exhibit 6. 14:49 14:50

My main contact in MAH is H502, Deputy Charge Nurse in Cranfield 1. I understand H502 is agency staff. There is a patient in Cranfield called P133 who comes into P113's room. He is a big man. He has complex needs and requires one to one care. P113 was due to come home on 5th of January 2023, when I received a telephone call from H503, who is a disability nurse in MAH, I cannot recall her surname, who told us about that P133 went into P113's bedroom while he was sleeping and slapped him on his head. When I was told about the incident, I was upset. I texted H498 at 9:00 p.m. that evening and told her I was very concerned that this would happen again. She said that she would liaise with the safeguarding team and add this incident 14:50 14:50 14:51

to her investigation. When P113 came home, he repeatedly talked about how P133 hit him.

Safeguarding within MAH carried out a risk assessment. P113's bedroom is through double fire doors and down a corridor. Cranfield 1 is a v-shaped building. P113's bedroom is first on the right on one side of the v and P133's room is on the other side down the corridor to the left. The doors are always left open, so I suggested to H504 that they be closed or some sort of deterrent was added. To 14:51 14:51

Prevent P133 from coming into P113's bedroom, staff changed the lock on the door to a round single cylinder deadbolt that can only be opened from the outside with a key. If P113 wants to leave his bedroom, he has to turn the handle on the inside and pulls the door open. Photographs of the handle in P133's bedroom are enclosed at Exhibit 7. 14:52

P133 has also hit P113 when he is in the day room in Cranfield 1. The day room is for P113's sole use and he particularly enjoys looking out the window. On several occasions P133 has come into the day room and hit P113, at least four times that I know off. 14:52 14:52

H502 reported an incident to me where P133 went into the day room and hit P113 when staff were distracted giving out medicine to residents and there were other

people on their break. They should allow staff to take breaks when medication is being administered."

Should that be they should not allow staff?

A. Yeah. 14:52

3 Q. So I'll read that in:

"They should not allow staff to take breaks when medication is being administered.

14:53

The day room is quite big and has a window at the end of it where P113 sits. I was concerned how long staff left P133 unsupervised, as he had time to get to the room, walk across the room and hit P113. When discussing the issue with H502 and H503, I suggested 14:53 that they make the direct route from the door to the window more difficult for P133 to walk through, for example by placing a Chair near P113. The response was that the chairs are heavy, so they cannot be removed.

14:53

To prevent P133 from going into the room, H504, Investigating Officer of Adult Safeguarding, arranged for the day room to be locked when P113 was in it. The lock was similar to a single cylinder deadbolt that can only be opened from the outside with a key, but it had 14:53 indents on the knob. P113 has poor motor skills and cannot hold a fork or pencil, so turning a stiff lock is difficult with him. I raised this with H504 and told him that I looked at the lock on the day room and

I found it stiff, which would make it difficult for P113 to use, as he does not know to turn it right around. Staff at MAH told me that when P113 could not open the door, he taps the window to get their attention and someone will open the door. I said to H504 that I did not like this, as I was concerned that the lack of freedom for P113 to leave the room when he wants would make him feel trapped. In addition, I wondered how long it takes for staff to hear P113 and open the door, especially when they are dealing with other patients. H504 said that he spoke to staff on the ward, who said that P113 was able to turn the lock and open the door. I asked for a bigger lock to be fitted. H504 agreed to look at the other options. 14:54 14:54

A new handle was put on the room, but this was harder to open. H502 said that P113 could not open the door with the new handle. The initial cylinder-type lock was put back on the door and remains there. I believe that staff only lock the door when P133 is around and leave it open otherwise. Attached at Exhibit 8 are photographs of the lock on the inside and exterior of the day room and my text exchange with H504. 14:55

Staff have told me that P133 has hit P113 four times. Although MAH is taking measures to prevent P133 hitting P113, I feel that they should take steps to ensure that patients who are more likely to hit out should be supervised to avoid this from happening, rather than 14:55

waiting to deal with the issue following complaints from peers.

H502 sent me an email on 4th May 2023 advising that P113 had been taken to a doctor as his left ear was swollen due to trauma from P113 hitting it. I was told that P113 kicked off, but I do not know why. I understand 'kicked off' to mean that P113 was shouting, screaming, hitting out, biting his hand and banging his hand against his ear. 14:55 14:56

P113 came home on 31st May 2023 and I noticed that he had a large black bruise along his left forearm and his left ear was swollen. H502 contacted me on either 23rd or 24th May 2023, before P113 became home, and was told that there had been an intervention. I raised this with H498 and she asked if I wanted to refer the matter to the Safeguarding team. I told her that I wanted the incident to be referred to Safeguarding. It was investigated and reported that P113 had been upset or resisted something and this is how he sustained the bruising. She also said that she 'will remind staff to request to notify next of kin when physical intervention is used'. I am not informed when physical intervention is required unless I ask. 14:56 14:56 14:56

The Northern Trust continue to work towards implementing a plan to move P113 out of MAH permanently. P113's father and I spoke to H186 in

August 2021, who told us that she might have found a suitable placement for P113 in a residential home which is part of Gold Healthcare. P113's father and I visited the residential home with H186 for the first time on 22nd September 2021. She showed us the accommodation that P113 will live in. I am impressed with what I have seen at the residential home. Each resident has their own bedroom, with a television and a wet room. Outside each room is a secure patio area that the resident can sit in. There are communal areas, one of which has windows that I know P113 will like to sit and look out at. 14:57 14:57

In May 2022 parents and carers of the residents who are resettled in that residential home were invited to a meeting with H304, Lead Resettlement Officer for the Northern Trust and the Assistant Director for Learning and Disability Services in the Northern Trust, who are part of the resettlement team. The meeting was held in person or over Zoom. P113's father and I attended the meeting in person. They said there was potential for some residents to be resettled within the residential home, as they are offering accommodation that may be suitable. We were told that an eight-bedroom unit purpose-built for people with disabilities so that they may live in supported living accommodation. 14:57 14:58 14:58

I remember that during that meeting H411 joined via Zoom. As I was disgusted by the way that H411 spoke to

P113's father and I at our meeting on 8th June 2018 and how the report of the first incidents were made to me, I left the room when she began to speak.

As a family, we are now planning P113's move to the residential home. Staff from the residential home have met with P113 and are working with MAH to familiarise him with the proposed new accommodation and ensure an appropriate care package is in place before he leaves MAH. It has been confirmed that P113 has been accepted into the new residential home. P113's father and I met with P113's MDT fortnightly to prepare P113 for resettlement. 14:59 14:59

This experience has been very traumatic for me and my family. We never wanted P113 to stay in MAH for as long as he has, but we have had no choice. I trusted staff at MAH and the Northern Trust to look after P113. I wonder how anyone can be so cruel. I feel completely let down by MAH, Belfast Trust and the Northern Trust. 14:59

Finding out that P113 was abused has affected my life dramatically. In June 2019 I took sick leave from work for one month, as processing what I was told happened to P113 was too much for me to cope with. This affected my husband and sons. I do not talk about this experience to anyone outside my immediate family. I want to protect my sons from the reality of what P113 has suffered. When I talk about what happened to P113, I feel physically sick and very emotional, which causes 15:00

me to lose my appetite and feel depressed.

P113's father and I will not live forever, so I want to ensure that he finds a permanent home to live in where all his needs are met and his brothers do not have to worry about him as I do. I want P113 to leave MAH as soon as possible and I worry that the longer P113 stays in MAH, the more difficult it will be for him to settle in the residential home. As a mother, all I want is for P113 to live in his own home, where he is well cared for, safe and happy." 15:00 15:00

P113's mum, that's the end of your statement. And if you flick over the page, you'll see at section 5 that you have signed it and dated it 6th September. So, having heard me read that out, can I ask you, just first of all, are you content to adopt that as part of your evidence to the Inquiry? 15:00

A. I do.

4 Q. I have been reading for some time now. Would you like a break before I start asking you questions? I think my questions will probably take about half an hour in total. 15:01

CHAIRPERSON: I think we ought to have a break, for the witnesses and for you. So if we just took 10 minutes or so now. 15:01

MS. KILEY: Yes, that's fine.

CHAIRPERSON: Is that all right? Okay.

MS. KILEY: Thank you Chair.

CHAIRPERSON: Okay, we'll just take 10 minutes. Thank you.

THE HEARING ADJOURNED FOR A SHORT TIME

15:01

THE HEARING RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you.

5 Q. MS. KILEY: Okay, P113's mum, you heard me do a lot of reading there and you've given a comprehensive statement, so the good news is I'm not going to ask you to repeat everything that you've already said in your statement, but there are a few issues that I just want to ask you some more questions about, okay? The first was a comment that you made about how long you thought P113 would be in Muckamore and your expectations for him. One of the things you said was Muckamore was not a place that you wanted your son to end up in. Why did you feel that way? 15:19 15:20

A. Well, my understanding was that P113 would get the treatment he needed and then he would move out to either supported living or residential. And we had kind of talked about this before P113 actually ended up in Muckamore, we'd sort of talked to a social worker about this and just, like, looking, you know, further down the line, that we weren't getting any younger, P113 wouldn't be at home forever, you know, and we had sort of talked about this before the breakdown really. 15:20 15:20

6 Q. About what would happen to him if something like this

happened, if a crisis situation happened?

A. Yeah, or something happened to one of us, we've talked about this as well. But Muckamore was never in the horizon, you know, to be a permanent place.

7 Q. And one of the other things you said was that when P113 was first admitted to Muckamore that you felt that you were naive about the care that they would give him. What did you mean by that? What do you think you were naive about? 15:21

A. Well, we didn't know what to expect. And there wasn't very many meetings to give us updates. And it seemed to be me that was asking all the questions, you know? And then in the statement I said that there was a social worker for the Trust that told me that I could take him home. But I mean, we didn't know what had happened. I knew that P113's behaviour hadn't changed, I knew that he was probably on a lot more drugs than he was when he went in. But I mean, things hadn't changed for us and everything back home had broke down - you know, like the day centre couldn't handle him, respite facility couldn't take him. So, like, every door seemed just to close. So nothing had really changed. And it was like 'right, he's been here for a while, so, you know, just take him home and see what happens'. 15:21 15:22

8 Q. And at that, or during that conversation was there any discussion about support that might be offered to you at home to help you do that? 15:22

A. I can't really remember. Because there's been so many meetings I've been at, so I can't really remember what

really was talked about. Like, I did say to the social worker at that meeting that that's not what has been in my mind, that it's not going to solve anything me taking him home again, his behaviour's still going to be the same. Our family life was zero. You know, I do think of the things that happened at home and it just wasn't good.

9 Q. And when P113 was admitted to Muckamore then, what sort of treatment did you expect him to get to help him with those behaviours? 15:23

A. I did expect that he would be on maybe a different type of medication that would maybe, you know, keep him quite calm, maybe some type of therapy that, obviously, we didn't know of that would change things.

10 Q. And at the time of P113's admission, did anyone explain to you the type of therapy that he would be offered or treatment of any kind? 15:23

A. From what I remember, there was not much chat of what was to happen. And in fact further down the line - and I can't really remember - there was a handbook give about Muckamore Abbey Hospital about if you'd any questions etc., it was colour photocopied brochure. But we didn't get that until P113 had been there for about a year. 15:24

11 Q. And before that time, did you have a named contact in Muckamore, a member of staff who you could go to if you had concerns? 15:24

A. There was always a key nurse, if that's the right wording. And it did change; because P113 had actually

went to three different places, his key nursed changed so many times. And then maybe staff moved, so then there'd been somebody else. So you were never quite sure of who to contact. And maybe some of the times when I was visiting, they were actually on a different shift. So you seemed just to be going from pillar to post trying to get answers and trying to get to talk to somebody.

12 Q. What about the MDT meetings? You refer to sometimes attending MDT meetings in your statement. How often did they happen? 15:25

A. The MDT meetings that I attended only -- I only attended when there was actually a place that had been located for P113 to go to. And that's when I started going to these MDT meetings. They seemed to have them once a week. I wasn't involved in the previous ones until they had highlighted where P113 was going to be placed. 15:25

13 Q. Right. So the MDT meetings were only a part of the resettlement process, is that right? 15:25

A. Yeah, the ones that I attended.

14 Q. Did you have any sort of regular meetings with staff at Muckamore aside from that process to discuss P113's care or the treatment that he was getting?

A. No. Just going into the ward, maybe talking to the nurse in charge, you maybe would've had a bit of a catchup there, but not anything formal. 15:26

15 Q. Do you know whether P113 received any psychological therapy in Muckamore or any behavioural therapies?

A. Yeah, he did. He did. There was behavioural team - now, I don't know how effective it was. But when it did come to him being relocated to the place in Templepatrick, they seemed to have disappeared. So all the behavioural support that he was supposed to have had and how they worked with him, to me just all disappeared, there didn't seem to be any support at all.

16 Q. When do you identify that that disappeared? Whenever... 15:26

A. When P113 had went out to the community, the unsuccessful --

17 Q. The first attempt at resettlement that was unsuccessful?

A. Yeah.

18 Q. Okay. And was it reinstated then whenever he went back to Muckamore, was that type of therapy reinstated? 15:27

A. I don't remember meeting anybody -- there was a lot of things had happened and then it was obviously identifying a place for P113 and then Covid. So I do not remember anybody else, any other behavioural professions, professionals, working with P113. 15:27

19 Q. Do you ever recall seeing a behavioural support plan or anything with that kind of name for P113?

A. Possibly. Yeah, possibly.

20 Q. One of the things that you had also mentioned there was medication and that you thought P113 might be on a different kind of medication whenever he was admitted to Muckamore. You describe a little bit about medication in your statement and particularly I want to 15:27

ask you about PRN. Because at paragraph 23 of your statement you say that when you visited your son, he seemed heavily medicated, and you said in fact a couple of times in your statement. Are you able to say how often that would've happened that you would've observed him in a state where you felt he was heavily medicated?

A. I couldn't really recall how often, but I would say for quite a while. We were going up and P113 could hardly -- he would stumble; we would've been out in the grounds or I would've took him maybe further afield and P113 would've stumbled. There was times you knew that he was completely -- his eyes were glazed, he would've been dribbling, you know, he'd just have been in a trance really. But as I say, unless I asked -- I knew by just looking at him. And then, of course, once I took him back into the ward again I was saying, you know, 'has P113 received PRN?' And then I would ask why this was. So it was me asking. There was maybe a few times I was told of incidents, but it was usually myself that would've been questioning why and when he was given the medication.

21 Q. You do mention in your statement times when you requested to be informed when P113 was given PRN and you've described there requesting it on certain occasions, but do you feel now that you are regularly informed whenever P113 receives PRN?

A. No. The last four weeks that P113 has been in Muckamore, there's been different things - he's actually broke a tooth in the last two weeks - and

we're waiting on Safeguarding coming up with their summary of what has happened. I always have to ask about PRN.

22 Q. And whenever you do ask, and in thinking back to those occasions which you've described in your statement where historically you have asked whether PRN has been administered, what response did you get about why it had been administered? 15:30

A. The majority of the time that I was given information about was that P113 had actually had a bit of a meltdown and there was no settling him and PRN was then given to P113. 15:30

23 Q. In your statement you said that you were concerned that PRN was used, what you described as a calming method. Can you explain to the Panel why you were concerned about that? 15:30

A. Well, probably we know P113 better than anybody, but I never give P113 PRN when he's at home. And I know it's a completely different setting. But you can talk P113 out of it, you can talk him out of it. And he gets very, very remorseful. It's like this big burst of energy and he gets violent and he hits and he hurts himself and, you know, he wants to lash out, but then he goes into a very calm, remorseful young man and you can talk him out and he'll actually say he's sorry. 15:31 15:31

24 Q. That experience that you have of being able to talk P113 out, do you ever share that with staff at Muckamore?

A. Yeah. P113's dad's the best that can talk P113 down.

25 Q. You've said in answer to my question there that you did discuss that with staff at Muckamore. Did you tell them the type of ways that you and P113's dad would use, the things that you would do to try and talk P113 down? 15:32

A. If I went in today to collect P113 and P113 tells you that he's been bad or he tells you that he's lashed out - and they see me, you know, they've got perfectly good hearing - and I would say 'you've just had a sad moment', so I'm going 'don't worry'. So this is the 15:32 way I talk him down, and they've seen us demonstrating this. I would say to P113 -- and I've said to people, sometimes I'm sure there's people think that 'she's going doolally', because I actually put a different accent on and I say 'don't worry', you know, 'it's 15:33 fine' and I always say 'you've had a wee sad movement, so let's move on'. So they see these things, you know? And I tell them, like I say all the time 'stop staring at him'. Because when you stare at P113, it attracts P113. He knows, he reads expressions, he knows that 15:33 people are watching him and so he reacts to that. You know, quite recently I've been up and there's all these agency workers and there's a guy who's standing peeking around the corner and I'm going, I actually said to the senior nurse 'please tell that person to stop looking 15:33 round the corner at P113, because that makes him feel uncomfortable'. It would make me feel uncomfortable. 'This chap has got learning difficulties', like, you know, 'stop doing that', you know?

26 Q. And you describe there the methods that you would use to try and calm P113 down and you're saying you would use those methods in Muckamore whenever you're seeing P113, is that right?

A. Yeah. If P113 tells me he's been upset or he's been bad, you know, I try to distract him. And I keep saying to them 'don't stand around him, don't stand around him', you know, 'move on, move on'. Like, you know, P113, it'll be stuck in his wee head and he'll go on and on and on, you know? And I say, you know, 'you just need to do things, you don't need to stand with him, you just need to move on'. 15:34 15:34

27 Q. And do you think staff have used that information that you have given them and used that to try and talk P113 down? 15:34

A. I think there's been a few staff, in all fairness. I don't believe now they're still there, but I think there's been a few staff that probably did use what I was saying that works best for us. But now the staff, every day I go in, there's somebody different, so it's kind of hard to keep up with the staff. And now that the two wards are amalgamated, it's even harder. 15:35

28 Q. I want to ask you a little bit more about your interactions with the Belfast Trust after you were informed about incidents that occurred at Muckamore. And you've described that in your statement. And in particular you described a meeting with Marie Heaney on 11th December 2018. And you've provided an exhibit at page 83 of your statement which I'd like you to turn 15:35

to, please. There are numbers at the top of the page and it will say 83, Exhibit 3.

A. Mhm-mhm.

29 Q. So you can see there that this is a letter from the Belfast Trust to you dated 20th December 2018. Is this the letter that was sent to you following that meeting on 11th December 2018? 15:36

A. It was.

30 Q. Yes. And you can see if you turn over the page that it's from Marie Heaney, the person that you met with, the Director of Adult Social and Primary Care Services. And fact just below that you can see it's copied to Margaret Flynn, who is the author of the report which you've also referred to your in your statement. 15:36

15:36

I just want to read out portions of that statement. If you look back at page 83 you'll see that it's said:

"Thank you so much for meeting with us last Tuesday, 11th December 2018. The account of your family experience was illuminating and sad. I understand why you state that 'we didn't have a family life' and that you want a better life for P113 and for all of you. 15:36

The decision to place P113 at Muckamore was a last resort and it was not the place you wanted him to end up long-term. 15:37

I agree with your assessment that the whole system is

wrong because of the absence of capable community support services for your family and for P113, including support away from his family. P113's exclusion from other services was upsetting for you all and the circumstances of his admission were very distressing. The staff did not know or did not use the information you had shared about P113 is so disappointing. You were told you could not take him home and you were promised a service which did not materialize and the insensitive way you were told about the incident which caused harm. So many opportunities were missed. Most particularly, your efforts to share your expertise and, specifically, effective ways of encouraging and engaging P113 were disregarded. This will change. 15:37 15:37 15:38

You were right to challenge the adult safeguarding policy and procedure and I agree that these failed P113 and others.

I welcome your professional experience and will be exploring the introduction of family/carer testimonials to test the quality of care and experience. 15:38

I wish that he had experienced some of the emotional sensitivity that he himself possesses. Despite all that you have gone through, I hope that you will be able to continue to work with us to improve P113's life and others. I will be communicating with all families 15:38

about this in the new year.

We spoke briefly about the Trust wishing to offer psychological services to any family member who would wish to consider this." 15:38

And then some contact details are given which it's said you can contact if you have any issues to raise.

There is a reference there in the first page that I referred to about your efforts to share expertise and, specifically, effective ways of encouraging and engaging P113 being disregarded. Is that the type of thing that you were just referring to, those types of triggers and ways of talking him down? 15:38 15:39

A. When P113 was admitted to Muckamore, we filled in a questionnaire, a sort of, it was a patient passport, if you want to call it, of things he liked, things he didn't like, things that would trigger him. And then when he was moved to all these, from one ward to another, the same questionnaire and the same form was handed to us. We actually said to each other one day, 'what happened to form? I thought it was all on computer'. But we were told it wasn't and all the staff didn't have access to the computer system. So there was a lot of effort went into, obviously, us telling the staff what we thought worked, but I don't know what happened that information. 15:39 15:39

31 Q. And is that one of the things you discussed with Marie

Heaney? And so is that what she's referring to whenever she says that efforts to share -- refers to your efforts to share expertise?

A. I think I told Marie Heaney my frustrations about things that I thought could improve. Because after all, my meeting this senior person was actually a fluke, because she met me at the review that Margaret Flynn had been chairing and it was only that I know she was being polite and she was asking us what we thought, how did it go and I actually made a few comments about that day and what had been said and we talked about P113 and why he had been admitted to the hospital and I guess that's why that meeting then was set up with Marie. 15:40 15:40

32 Q. There is a promise there when discussing those issues, you'll see the line, it says "This will change". 15:41

A. Yeah.

33 Q. P113 is obviously still in Muckamore. Have you seen any change?

A. In what respect? 15:41

34 Q. Well, what she says is that she refers to the efforts to share information and give effective ways of encouraging and engaging P113 which she says there were disregarded and she says that that's what's going to change. Have you seen any change in your communication with staff about those things and whether they're using those ideas that you give them? 15:41

A. No, I haven't seen any change.

35 Q. What about -- there's reference also to exploring the

introduction of family/carer testimonials; have you been asked to give one of those?

A. That wasn't my idea, that was Ms. Heaney's idea. And I guess she wanted maybe myself and my husband to get involved. But I didn't go down that route. 15:42

36 Q. Okay.

A. That was probably said at the moment.

37 Q. Okay. But that's not something that you have engaged in?

A. No. No. 15:42

38 Q. Okay. The final topic that I want to ask you about is resettlement. You described an earlier failed resettlement process and in your statement you've given a significant amount of detail for that. You now describe the planning that's ongoing for another 15:42 attempt at resettling P113 and the work that's ongoing in respect of that. So there are MDT meetings, I think, in respect of that, is that right?

A. There are.

39 Q. And they're fortnightly? 15:43

A. Fortnightly, but with the proposal that they're going to be weekly very soon.

40 Q. Right, okay. And compared to -- so, thinking of the process now that's being undertaken to prepare P113 for resettlement and comparing that to the earlier process 15:43 which ultimately failed, do you think that their preparations this time are better or any different than before?

A. I think they're better. But there is always that doubt

at the back of my mind, like, what if it doesn't work? What's plan B? It's just, it's just the way I'm set up that I just think is there something going to go wrong? I'm always thinking maybe on a negative side. But definitely there's a lot more effort, I have to say, everybody seems very committed.

41 Q. And do you have any indication of when the resettlement might take place?

A. Before Christmas, we've been told.

42 Q. Okay. 15:44

A. So...

43 Q. Okay. And you have provided the Inquiry, they're not attached to your statement, but yesterday you helpfully provided us with some photos that you would like the Panel members to see of P113, so I think we can bring 15:44 those up now. And if you look on your screen, you'll see them. So there are six photos and you can see it's P113 - are these all taken at home?

A. Yeah, these are all when P113's home at the weekends. He just gets the run of the house. 15:44

44 Q. Are these recent photographs?

A. These are recent. These are probably from Easter until now.

45 Q. And if we keep flicking through them please. He's enjoying, what, a milkshake there? Some shopping. And 15:45 the last one. So those are the photos that you want the Panel to see about P113. What would you like the Panel to understand about what P113's like, what type of person he is?

A. When P113's in good form, he's smiley, he laughs very heartily. He loves eating. He has to have a magazine, he lives around his magazine deliveries. And he actually loves home life, as long as it's his dad and myself and the dog, he just loves being home with us. 15:45
He's quite sociable when he's out - we try to get him out - you know, because he knows then people's not coming with us. He does have -- he's very anxious if people would come into our space, into our home, he's still a bit anxious. I'm not saying that every 15:46
weekend's good, but the majority of the weekends is good at home, you know? It is hard work, but we just try and keep that time for P113 and we try to keep him up as long as possible and do things.

46 Q. Like the various outings we've seen in the photographs? 15:46

A. Yeah.

MS. KILEY: Okay. Well, those are all the questions that I have for you and I'll pass over to the Panel, who may have some questions for you.

CHAIRPERSON: Yes, Professor Murphy. 15:46

P113'S MOTHER WAS THEN QUESTIONED BY THE PANEL, AS FOLLOWS:

47 Q. PROFESSOR MURPHY: Thank you for explaining about 15:47
P113's time in Muckamore. You've said that several times over you had to do these questionnaires about what he likes, what he doesn't like, what triggers him and I was wondering is one of the things he likes lots

of activities for him - I don't mean big parties, I mean activities that he wanted to engage in? Because looking at your photos, he's out in the community, shopping, walking the dog. Were those the kinds of things that you listed as his likes? 15:47

A. Yeah. We know that maybe wasn't possible in Muckamore, but, you know, I had took things in that thought maybe that P113 could do in Muckamore and never actually seen him, never actually seen the stuff that I'd brought in either. It maybe would've been something that they'd 15:48 have tried once and then if P113 hadn't engaged, that was it.

Like, it was a big concern that P113 wasn't getting out, getting fresh air. This was such a big concern. 15:48 Like, it was probably one of -- the sentence that I kept repeating, that I actually said to an OT 'listen, if P113 won't go out, put him in a wheelchair. I know that he can walk, but put him in a wheelchair'. When P113's behaviour started to escalate, we would've got a 15:48 wheelchair to take him, to go through an airport. And we told them all this. And I said, you know, 'if you could get P113 out, you could maybe win his trust. You know, his anxiety might disappear and he could maybe walk back', you know, 'just get him out in the fresh 15:49 air'. And it's all about making that relationship with P113.

48 Q. Yeah.

A. But until today, he has never sat in a wheelchair, that

I know of, in Muckamore, just to get him out in the fresh air. He has been out --

49 Q. So that was one of the ways you calmed him down?

A. He didn't have to -- P113 was safe, he was in that chair. You know, I explained that's how P113, I think, felt. 15:49

50 Q. Did he get to go to the day care at Muckamore?

A. They tried briefly. They tried briefly, you know. But we actually had went over a few times to the day care with P113, but then he maybe was reluctant to go, maybe he refused. And it obviously was having an impact on P113. And I know sometimes when they said to me that they maybe tried something, I'm saying 'look, you know what? Don't force him.' Because if you force P113, that's a bad experience, and P113 will never do anything like that. 15:49 15:50

51 Q. But I guess there might have been some things about the day care that was just what P113 didn't like. For example, it might've been very busy it. And sounds like he likes his own space, he likes to eat on his own, he likes not too many people around. 15:50

A. Yeah, totally.

PROFESSOR MURPHY: Okay, thank you.

52 Q. CHAIRPERSON: So, just picking up on that same theme, what is there for P113 to do during the day? When you're not taking him out or doing things with him, do you know what he does do? 15:50

A. It used to be that there was a person who came in and would've, it was like aromatherapy. And P113 would've

participated usually. But then there was days he was maybe a bit off, or it was a Friday and he was going out with us, or he was maybe going to go home, so he refused.

There would've been people coming in, there was people, I don't know if they still come in, maybe with pets and things and they would've maybe took some of the animals into P113's day room, day space. The OTs were in and out as well, there was some activities they would've liked P113 to get involved in as well. But it all depends on P113's mood. It all depends on P113's mood and how he's feeling. 15:51 15:51

53 Q. And the resettlement place that you looked at that you quite liked, is that the same resettlement place that is being considered for P113 now? 15:51

A. Ehm...

54 Q. You mentioned the eight-bedroom place that you --

A. Yes, yes.

55 Q. -- went and saw. 15:52

A. Yeah.

56 Q. Is that what's being considered for him now?

A. Yeah.

57 Q. And can I just ask, does that have -- is that a shared kitchen? 15:52

A. There's no kitchen. It's on two floors, so the kitchen and the team are all upstairs. They get their meals delivered to them or they can go to a communal area, depending on the client. They've successfully

resettled five patients, I think, now and P113's the next in line.

58 Q. Okay. And you were also asked by Ms. Kiley why you didn't go down the route of family and carer testimonials. Can you just tell me a little bit about that? What was the idea and why didn't you go down that route? 15:52

A. I just felt that I wasn't the right person. I was really angry, I just felt that P113 was being overlooked and I just felt like a testimonial is from the heart and I couldn't give it from the heart. 15:53

59 Q. So what were you being asked - forgive me for asking, I obviously don't want to upset you. I want to understand --

A. I think it was about, from what I remember, about the care or maybe after a while -- I know I was told there was going to be additional training, they had plans to make Muckamore, you know, a better place etc., but I wasn't willing to... 15:53

60 Q. No. 15:53

A. ... you know?

61 Q. But they were inviting you to contribute to that, but you didn't feel --

A. If I wanted to.

62 Q. No, absolutely, I understand that. 15:53

A. If I wanted to.

63 Q. But you didn't feel you were in the right place to do that?

A. You know?

CHAIRPERSON: Okay. Well, look, thank you very much. How are we going to deal with the next part?

MS. KILEY: I thought, subject to you, Chair, that we would deal with P113's dad first, because there is a statement to be read in that open session. 15:54

CHAIRPERSON: And then go to restricted session?

MS. KILEY: And then go into restricted session with both P113's mum and dad, because I won't actually have any questions and so I don't intend to ask questions about the matters that are going to be subject to restriction. 15:54

CHAIRPERSON: No, that's fine. Do we need to rise or can we just switch places?

MS. KILEY: We'll just switch over.

15:54

P113'S FATHER, HAVING BEEN SWORN, WAS DIRECTLY EXAMINED BY MS. KILEY AS FOLLOWS:

64 Q. MS. KILEY: Okay, P113's dad - that's what I am going to refer to you as - we met earlier on this afternoon, 15:55 which probably seems like a long time ago now. But the good news is that I probably won't be as long with you, your statement is a little bit shorter than P113's mum's. So I am going to follow the same process, I will read out the statement and I'll then have just a 15:55 couple of questions for you.

So the statement is in front of you. I can see the family liaison officer helping you with that. Let me

know whenever you have it.

CHAIRPERSON: It should start straight after the other one and it's...

MS. KILEY: It should be at the back of the file. That's it, yeah. 15:55

CHAIRPERSON: Does it have 149 at the top? MAH-ISTN-1491?

A. Yeah.

65 Q. MS. KILEY: That's it. That's yours. And you can see in front of you you've got the cipher list if you want 15:55 to follow along to see who I'm referring to whenever I use those references.

So your statement is dated 6th of September 2023 and you say: 15:56

"I, P113's father, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement. Family liaison Officer FLSW2 attended with me when I was 15:56 making this statement.

My connection with MAH is that I am a relative of a patient who is at MAH. The relevant time period that I can speak about is between 13th April 2017 to the date 15:56 of my statement.

My wife, P113's mother, has provided a comprehensive statement to the Inquiry dated 6th September 2023. I

have read her statement and I wish to add the following information.

My son P113 was admitted to MAH on 13th April 2017. P113 was diagnosed with a severe learning disability, autism, conversion chromosome 3 and a tic disorder when he was 13 or 14 years old. He is under the care of the Northern Health and Social Care Trust. His appointed social worker was SW11. 15:56

15:57

P113's mother has set out a history of treatment and support provided to P113 and the circumstances that led to him being admitted to MAH."

Then at paragraph 5 you refer again to P113's admission to the Iveagh Centre, which we've already seen in P113's mum's statement. That took place in December 2014. I'm not going to read that aloud, but in the final few sentences you say about that: 15:57

15:57

"I remember sitting in the car with P113 and feeling distressed, as I did not know what the admission to a secure unit would mean for P113 in the future. This was a very uncertain time for me. I tried to keep calm as I did not want to upset P113. P113 was unaware that he was going to the Iveagh Centre. He stayed at the Iveagh Centre until 25th December 2014, as he turned 18 the following day." 15:57

Then at paragraph 6 and 7 you set out some more information about the period leading unto P113's admission to Muckamore Abbey Hospital, which you describe as being very stressful. And I won't read out all of that out, but I'll pick up at paragraph 8, where you say: 15:58

"When we arrived at MAH, I remember seeing police officers and staff from MAH in the foyer of PICU. They told P113's mother and I why P113 had to be admitted to MAH and that it was in his best interests. The decision to admit P113 to MAH was out of our hands, so I trusted the professionals. Everyone conducted themselves in a pleasant manner and I felt reassured that they could help P113. I was told that P113 was admitted to the PICU ward for assessment. I thought that P113 would stay in MAH for a short period and did not imagine that he would be there almost six and a half years later. 15:58 15:58

I was unable to visit P113 for approximately one week after his admission as he was under assessment. P113's mother telephoned MAH every day to find out how P113 was and asked when we could see him. 15:59

When we were permitted to see P113 in PICU, I remembered thinking the staff who cared for him seemed pleasant. They gave the impression that they were looking after P113 appropriately and he was doing well.

I remember there were times when I thought P113 was over-medicated, as he was lethargic, but I trusted that his care team were acting in his best interests. I am aware that PRN was administered to P113, but I do not know if this is why he seemed heavily medicated. 15:59

I am aware that H89 worked in PICU when P113 was a patient there. I did not know H89 before P113 was admitted to PICU, but was aware that P113's mother knew her from school. She was friendly and gave me no cause for concern. 15:59

P113 stayed in PICU for approximately three weeks and then moved to Cranfield 1. On the day that P113 moved to Cranfield 1, P113's mother and I were visiting, so we walked him to Cranfield 1. 15:59

I visit P113 on Friday and Sunday of each week with P113's mother. We take him out of MAH on a Friday and bring him around the shops for something to eat. There were times when we called on a Friday to collect P113 when he was not dressed or he was wearing old, worn clothes. P113's mother and I buy P113 new clothes regularly as it is important to us that he is well dressed and has clean, good quality and comfortable clothes to wear. Before they are given to staff in MAH, P113's mother put them in a bag with a label on it saying that they need to be sent to the laundry for 16:00 16:00

P113's name to be put on them. This helps ensure that when they are washed in the laundrette, they are easily identified as P113's clothes so they can be brought back to him.

16:00

There have been times when we are looking for an item of clothing for P113 to wear and it cannot be found. For example, my mother bought P113 a new Adidas top that cost £45 and we noticed on a visit six months later that another resident was wearing it. Sometimes 16:00 clothes disappear. When I ask staff where P113's clothes are, I am told that they are most likely in the laundry room.

There have been several occasions when I have went to 16:01 the laundry room with staff to try to find P113's clothes. The laundry room is a large industrial room with washing machines and driers. Patients' clothes are organised into a box with their name on it. When looking for P113's clothes, staff search through 16:01 patient boxes and ask me to identify any clothes that belong to P113. I do not look through the boxes, but observe staff. There are times when P113's clothes are found in another patient's box and times when they cannot be found. When I ask why his clothes have been 16:01 put into another patient's box, I am told that mixups happen.

P113 sent his 21st birthday in MAH. We brought

presents, balloons and cake to P113. I found this day difficult, as celebrating his 21st in MAH was not what I had imagined. Along with P113's mother and P113's two brothers, we did our best celebrate the day for P113.

There have been attempts to resettle P113 in the community."

And you then describe the efforts to resettle P113 into a residential care home, which you've already heard P113's mum describe. And I won't read all of that aloud again, but I'll pick up then at paragraph 16. And you can see you say:

"I think that P113's move to the residential unit was unsuccessful due to a lack of planning and staff training. The resettlement team expected P113 to transition without any issues. He needs time to settle in new environments and he needs appropriate support. The fact that MAH staff were told by the residential unit not to visit P113 any more would not have helped him. In addition, the layout of the bungalow was not suitable for P113's needs. P113's room was at the back right side of the bungalow his day room was at the back left side of the bungalow, which meant that he had to walk past the kitchen and bathroom to get there. P113 needs direct access to his day room from his bedroom so that he does not become upset or frustrated if he does

not have a clear path to get there.

I became aware that allegations of abuse had been made against staff in MAH in late summer of 2017 after P113's mother spoke with Glynn, who is the father of a patient at MAH. We were visiting P113 in his bedroom on Cranfield 1 shortly after we found out about the allegations when a member of staff in MAH called H457 came into his room. H457 was nice and friendly and usually spoke to me and P113's mother. P113's mother was with P113 and I turned to speak to H457. When I looked at her, she began to cry and said 'I'm sorry'. I asked her what she said and she said 'I'm sorry' again and left the room. I do not know why she said this and asked P113's mother what she thought she meant by this. I wondered if H457 had seen something that she did not report or if she was involved in the abuse. I still do not know the reason she said this. 16:03 16:03 16:04

I was not aware that P113 had been subject to abuse until May 2018. P113's mother and I had taken P113 to the Tower Centre in Ballymena, when P113's mother told me that she received a voicemail from someone at MAH and she wondered if this meant that P113 was involved. When P113's mother answered the second phone call, I was shocked beyond belief that P113 had suffered abuse by those who were caring for him. 16:04 16:04

P113's mother could not tell me too much at this time,

as we were with P113 and did not want to upset him. As P113's mother has set out, P113 picks up on behaviours and if he had picked up that something was wrong, this would have upset him. P113's mother and I took P113 back to MAH and we discussed what she was told when we got home. 16:04

I feel the way that P113's mother was told about the incidents over the phone was not professional. I was annoyed that they put the burden of having to tell me what happened to P113 on P113's mother and they should have told us in person together. I believed that P113 was in a safe and secure surrounding and that he was being looked after by professional people. I was angry to find out that he was not. 16:05 16:05

Following this phone call, P113's mother and I met with H411 on 8th June 2018. P113's mother has set out the experience in full and I agree with her description of the meeting. My intention for the meeting was to find out what happened and how P113 was involved. I asked H411 if the incidents of abuse were known because of a whistleblower within the Belfast Trust, as we had heard a member of staff had spoken out. She said there was no whistleblower. 16:05 16:05

After P113's mum and I found out about the abuse, the PSNI met with us at our home. They told us they were reviewing CCTV footage and would report any incidents

involving P113 to us. They were sympathetic and tried to assure us that justice would be served. We discussed the best way for incidents involving P113 to be reported to us. The PSNI agreed to contact P113's mother to report any new incidents. 16:06

The PSNI introduced P113's mother and I to Family Liaison Social Worker 2, a family liaison officer, on the 19th February 2020. The family liaison officer asked if P113's mother and I would like to attend 16:06 counselling services with a psychologist who worked in Belfast. We decided that this would help and we met with the psychologist over Zoom between July 2020 and October 2020. I talked about how I felt when I heard P113 was treated in MAH. P113's mother and I talked 16:06 openly and found that these sessions really helped us process our feelings.

At paragraph 57 of P113's mother's statement she refers to a text message from H498, who is part of the 16:06 safeguarding social work staff in the Belfast Trust that records I picked P113 up from MAH at 11:30 following an incident on 16th December 2022 where P113 banged his head against doors and chased staff. Restraint was used PRN was administered. I do not 16:07 recall this day and do not recall ever collecting P113 from MAH at 11:30 p.m. This may be a typographical error and should read 11:30 a.m. I do not recall any member of staff telling me about the incident and that

PRN was administered when I collected P113 from MAH."

Then moving over to paragraph 23, you say:

"I am pleased that P113 is due to leave MAH soon. The resettlement team within the Northern Trust have found suitable accommodation in a residential home for P113 to move to. The residential home is located close to our home." 16:07

16:07

And you name someone who showed P113's mother -- you say that person "showed P113's mother and I the property, which seems to meet P113's needs.

Staff in the residential home have met with P113 and they are working with MAH to familiarise him with his new accommodation and ensure an appropriate care package is in place before he leaves MAH. 16:08

P113's mother and I meet with the multidisciplinary team every fortnight to discuss P113's resettlement plan. I find it unbelievable that so many incidents happened right under my nose. The staff involved covered up what was happening and lied to me and P113's mother when we asked about P113. It makes me angry to think about how my son has suffered. I feel helpless, as I did not know that P113 was suffering, so I could do nothing about it. P113 cannot tell me what happened, so I may never know full details. I feel let 16:08

down by MAH, as I trusted that my son would be looked after in a safe and secure environment. I hope that when P113 moves to the residential home that he will be cared for and looked after as expected by care professionals and that he is happy." 16:09

And that is the end of your statement, which you then sign and it's dated 6th September. So, having heard me read that aloud, are you happy with the contents of your statement, first of all? 16:09

A. I am, yeah.

66 Q. And do you wish to adopt it as part of your evidence to the Inquiry?

A. Yes.

67 Q. Okay. Again, I'm not going to ask you to go through every thing that you have already said in your statement. You have heard P113's mum give evidence; do you agree with the experiences that she has outlined to the Inquiry? 16:09

A. Yeah. Yes. 16:09

68 Q. And did you have similar experiences to P113's mum?

A. Yeah.

69 Q. And similar feelings about the treatment of P113 at Muckamore?

A. Totally. 16:09

70 Q. One of the things that I wanted to ask you particularly about was P113's admission to Muckamore. Because you described it as being out of your hands. Was there a frustration there at that time?

A. When P113 was admitted to Muckamore?
71 Q. Admitted, yeah.
A. Was there a frustration?
72 Q. A frustration at it being out of your hands.
A. Yeah, I suppose. But, here, when you think about it, it was something that had to happen. You know, P113 was just escalating out of control and... 16:10
73 Q. And he was detained formally under the Mental Health Order.
A. Yeah. 16:10
74 Q. You describe what happened whenever you arrived at Muckamore with P113 and the police officers. At that time did anyone explain to you what would happen to P113 whenever he was in Muckamore?
A. I can't remember. 16:10
75 Q. And can you remember if at that time, or at any time, you were ever told what rights you had as a parent of someone who was detained under the Mental Health Order?
A. No, I don't remember.
76 Q. Do you ever remember receiving a leaflet or a letter of that kind saying, telling you about your rights or what you could do given that P113 was detained? 16:11
A. I can't remember back.
77 Q. Nothing?
A. No, I don't know. I would need to... 16:11
78 Q. No, that's okay. That's okay. I, as I say, am not going to ask you to repeat everything that P113's mum has said, so there is nothing more specific arising from your statement that I wanted to ask you about. As

you know, there was a paragraph that I haven't read, which we will come on to, but excepting that paragraph, so forgetting about those incidents, is there anything else that you would like the Inquiry to know about your experience at Muckamore? 16:11

A. No.

MS. KILEY: Okay. Well, I have no other questions for you. The Panel might.

CHAIRPERSON: No, the Panel don't have any questions either, so I think your wife has actually covered it. 16:12 But thank you very much indeed for coming to assist. So we've got to move on into restricted...

MS. KILEY: Into restricted session. And if we do that, both witnesses remain sworn, so all I intend to do is to read the relevant portions of each statement 16:12 aloud and have it adopted.

CHAIRPERSON: Sure. Okay. So could we deal with the father first perhaps, since he's sitting there.

THE INQUIRY THEN WENT INTO RESTRICTED SESSION 16:12