MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 15TH NOVEMBER 2023 - DAY 70

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THE INQUIRY RESUMED ON WEDNESDAY, 15TH NOVEMBER 2023 AS FOLLOWS:

CHAIRPERSON: Good morning. Yes, Ms. Bergin.
MS. BERGIN: Good morning, Chair, Panel. This morning's witness is Phillip Ward. The witness is ready to proceed when the Panel is and there are no complications. 10:00
CHAIRPERSON: Let's get the witness in.
MS. BERGIN: I should say for the record that the statement reference is STM-190 and the witness is happy to be referred to as Phillip. 10:00
CHAIRPERSON: But he's not ciphered at all, is he?
MS. BERGIN: No, he is not.
CHAIRPERSON: So we can have his surname? 10:00
MS. BERGIN: Yes.

MR. PHILLIP WARD, SWORN, QUESTIONED BY MS. BERGIN:

CHAIRPERSON: Mr. Ward, can I just welcome you to the Inquiry, I'm sorry we haven't met. There were things going on that stopped me from coming to see you. I just want to thank you for coming along to help the Inquiry. It's always a bit nerve wracking when you start, every witness who sits there, I am afraid, feels that. But within a minute or two, I'm sure you will be comfortable. All we want to hear is obviously your evidence so I will hand you over to Ms. Bergin. 10:01 10:01
MS. BERGIN: Thank you, Chair. Good morning, Phillip.

As you know I am one of the counsel to the Inquiry and we met briefly this morning and I explained to you the procedure that we will be following. The first thing I am going to do is read your statement aloud and then I will ask you some questions and as we said, the Panel may have some questions. You should have two documents in front of you, firstly your statement to the Inquiry and then also a cipher sheet and I have explained to you how that works so you can follow along when I'm reading. 10:01 10:02

CHAIRPERSON: If you can just remember the stenographer and take it a bit slowly.

1 Q. MS. BERGIN: Certainly Chair, thank you. As I'm reading, Phillip, as I already explained, there may be some parts of your statement that I am going to skip over or paraphrase and I have explained to you why we are doing that. But, as I have already explained to you the Chair and Panel have read and do have in front of them your full statement okay? 10:02

A. Yes. 10:02

2 Q. All right, so you have made a statement to the Inquiry which is dated the 22nd of November 2023 and you say,

"My connection with MAH is that I was employed as a full-time day care worker with the South Eastern Health and Social Care Trust. This was a Band 5 role. The relevant time periods that I can speak about are between the 1st February 2008 and 26th of April 2010, and July 2022 and December 2022." 10:02

Then at paragraph 3, which I'm not going to read out in full, you describe your qualifications and your experience prior to taking up your role at MAH and you say that you undertook a HND qualification in health and social care. You describe working with an autism charity between 2005 and 2006 supporting people with learning disabilities with self-care, eating and learning activities.

10:03

You say that you achieved a level 5 in studies and then between 2006 and 2008 you worked for the Belfast Trust in a day centre which provides activities for adults with learning disabilities.

10:03

You then applied for the role as a day care worker at MAH and you were successful in your application. And at the end of that paragraph you then say: "I remember when I told" and you name the manager of the day centre you were working in:

10:04

10:04

"That I was leaving to work in MAH that he asked me why I wanted to work in MAH. He said that it has a reputation as a tough place to work and recommended that I stay no longer than one year as there was a high level of burnout amongst staff."

10:04

You then say:

"I began working as a day care worker in Moyola Day

Centre, Moyola on the 1st February 2008. I worked 37 and a half hours a week, Monday to Friday. I did not know anyone who worked in MAH and had no family connections. My induction to Moyola was conducted by H722, manager, and included a walk around the centre and introductions to staff and patients. I cannot recall but I may have been given a standard form with details of my line manager and other relevant information and health and safety training. I remember being told that I cannot assist staff with restraining patients as I was required to undertake management of actual or potential aggression, MAPA training. I did receive further training in MAH. I believe I attended a MAPA refresher course. I cannot recall for certain but I think I attended training on manual handling and fire safety. Training was carried out during the working day. 10:04 10:05 10:05

The manager of Moyola was H77, I believe that he held a senior role in MAH and also managed the wards. My line manager was H722. Moyola was undergoing changes as a new facility was due to open shortly after I joined. I worked in the old building for a short period and was then moved to the new building. The rooms in the old building there were adjoining rooms, whereas in the new building the rooms were separate and could only be accessed through the main door. 10:05 10:06

My first thought when seeing MAH was that it was very

far away from Antrim Town and other buildings and people generally. It was a massive site with a lot of buildings. Moyola was busy, there were a lot of staff and patients. I thought the facilities and the rooms were quite good in the new building. It was warm, there was good lighting, good maintenance support and a swimming pool that the service users enjoyed using. 10:06

My normal working day was structured and activities were set out on a timetable. Activities included taking patients to the swimming pool, playing and learning in the recreation hall, themed events and outings. During the activities I assessed if the patient required further assistance with their learning and development. If I identified a need, I added this to the daily report so it could be considered by those responsible for the patient's care plan. I had access to the day care notes but I did not have access to ward notes. I tried to make the activities fun for the patients. 10:06 10:07 10:07

Patients usually ate their lunch on the ward so I was not with them during this time. We gave patients tea and biscuits in the room. On occasions when we took patients on a day trip the ward made staff aware of any swallowing guidelines. 10:07

When taking patients to the swimming pool, we ensured that one to one support was provided if required and

that there were enough male/female staff to go to the changing rooms with patients.

When I first joined Moyola I felt very much like an outsider as I was aware that a lot of family members worked in the day care centre, the day centre and throughout MAH. Those who were connected by family were mostly from Antrim and it seemed that they did not want people who were not related to them to join them. I remember being told by a member of staff, whose name I cannot recall, not to upset certain members of staff as they were related to senior staff within MAH." 10:08 10:08

I am going to now paraphrase the remainder of that paragraph, Philip. You then give an example of a member of staff who was related to someone in a senior position and had other relatives working in the hospital. You say that this particular member of staff was very confident in their behaviours, that that seemed to be their personality type. They worked with patients with complex needs and sometimes, in your opinion, they were too stern with patients when it was not required and that they often behaved that way towards staff. 10:08 10:08

You say that you were concerned that this member of staff may go back to the senior staff member and cause trouble for you. That made you feel uneasy and so you avoided having any challenging conversations with that 10:09

member of staff and others who were related to each other.

You were not concerned about the staff member's behaviour in the context of abuse but you do think they could have taken a different approach with patients and staff at times. You then continue: 10:09

"Reporting incidents involving patients and staff was not welcomed by H722. When I first started to work in Moyola I reported any incidents that occurred during the day. For example, if a patient hit or bit another patient or me, I would report this in my end of day report. H722 asked me why I was reporting on patient behaviours like punching and pulling hair, and completing the incident forms that she has to review. She told me that the patients in MAH often had complex needs and it was expected that they would hit out or injure patients and staff so there was no need to report on any incidents. She made it clear that she was unhappy with me completing the incident forms and that she found me annoying. She said to me, 'in the community they cannot cope with challenging behaviour. If someone gives someone the slightest slap they send them up here' and then she laughed. She said 'you see, Phillip, we are at the end of the road for those with challenging behaviour'. Her attitude was this is what you signed up for, we are all in the same boat so just get on with things and stop completing incident forms. 10:09 10:10 10:10

After this conversation I rarely completed incident forms. At the time I was not aware of the process that H722 should have followed. As I am now more experienced I can see that she should have reviewed the incidents and taken any appropriate steps. This attitude reflected the culture in Moyola.

There were times when agency bank staff worked in Moyola. I remember a lady called H725 who worked on one of the wards. She took patients to Moyola. I do not know exactly when she worked in MAH and I cannot recall her surname. She was very nice and good with patients.

10:11

I was told by a member of staff, H724, who was a fellow day care worker who I worked with and a close friend to H725, that H725 was not returning to work as she had reported a staff member who had pushed patients. H725 had witnessed the abuse and reported it. H725 told me that a nurse had pushed a patient on to their bed in a forceful way. She reported the incident and since then she was bullied by staff on the ward that she was working on. She said that she could no longer work in MAH because of the bullying she experienced since reporting the incident. She told me that it was a respected and important name in MAH. The Belfast Trust may have a record of the report filed by H725 that provides details of the individuals involved.

At the end of each day I completed a report setting out the activities each patient engaged in, the level of interaction and progress. The report was handwritten and placed on the patient's file. The patient's file gives a list of behaviours displayed when they are unsettled. This means it is not necessary to record the nature of these behaviours when completing the daily report and they were recorded as unsettled behaviour. The use of "unsettled" is purposely vague as it is accepted amongst care staff that if the term is used about a patient that I am familiar with and know their common difficult behaviours. The true meaning behind the term "unsettled" could only be determined when speaking to the staff member who completed the report. If however, a patient did something out of the ordinary, for example, took their clothes off or spat, then this would be recorded as "new behaviours that may need to be investigated". Sometimes patients copied the behaviour of other patients which we determined as learned behaviour. Although I reported the change in behaviour, this was expected as this was the nature of the environment. I identified areas where a patient needed help to develop. I did not assess physical health needs of patients as this was not within my remit. There was a duty on staff to tell those within Moyola and also on hand over of the patient any new risks involving the patient.

10:12 10:13 10:13 10:13 10:14

As part of my role, I completed a quarterly report that was issued to senior members of staff. This was a short report to management in Moyola and ward staff. The report was general and included details of patient engagement in activities and any issues flagged. The report would be reviewed by medical-led staff to include consultants, nurses and ward managers. The report included details of activities the patient was involved in, whether any behavioural support was required when attending day care, for example, help with speech and language. I was not involved in any therapeutic decisions or medical decisions but I was made aware of any behavioural therapy care plan by the ward staff.

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I attended management discussion team, MDT meetings to discuss the patient. As I was a day care worker, I was largely ignored by the medical staff. I attended meetings with..."

10:15

And you name a consultant psychiatrist with the Belfast Trust.

"...Dr. H40 consultant psychiatrist with the Belfast Trust, amongst other staff, however, I cannot recall their names. I remember one meeting where a patient attended to advocate for herself. The MDT were discussing moving her to the community. The patient said that she did not want to leave MAH as she was

10:15

afraid she could not live in the community. She had friends, a bed and food in MAH and did not want to leave. I was flabbergasted that she said this. It was clear to me that she was very distressed about having to leave MAH as she said she did not know much details about her new placement and it worried and angered her. I think the patient was moved out of MAH. I did not raise my concerns at that meeting, however, I did raise them during a one to one conversation with a female nurse or consultant, I cannot recall their name, when I asked why patients did not want to leave as I found it unusual that someone would want to stay at MAH. She laughed at me and did not answer my question. She told me that it cost approximately £60,000 to look after a patient in MAH and that it cost over £100,000 to care for patients in the community. Her response made me feel like I was asking a stupid question so I said nothing further. I felt very embarrassed at this time.

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I recall attending a meeting where a patient, who I think was called P76, had lived in the community but the transition was not successful so he moved back to MAH. I remember the patient seemed nervous. One of the nursing staff, whose name I cannot recall, said to the patient that he was back again and how long did he intend to stay in MAH this time and laughed at him in front of him and other staff. The patient laughed nervously in response and was quiet. I thought this was inappropriate. I did not raise any concerns about

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this as the culture within MAH taught me not to.

It was policy that staff should not be left alone with high risk patients who could hit out and injure them. We were given a personal alarm that I carried with me at all times. There were a number of occasions when I was left alone with patients. I recall two occasions in particular. The first incident occurred with a patient who required two staff members to be with them. I found myself in the day care room alone with him. The patient punched me. This was first thing in the morning when staff were just arriving so there was not enough staff around so I did not use the alarm. I managed to run away from the patient. I reported the incident to H722 but she did not do anything about it. 10:18

Another incident occurred in the recreation hall where a patient threw snooker balls and a cue at me. I was tidying up after the day's activities. The patient locked the door to stop me getting out. I was able to unlock the door and leave the room without being injured. I could not use the personal alarm as the recreational room was too far away from the Moyola building. I reported this incident to H722, however she did not take any steps to deal with the incident. 10:19 It was very clear that staff were expected to tolerate injurious behaviours from patients and, as such, incidents that someone who did not work in Moyola may say should be reported were considered part of the job

and staff were to accept it and not complain.

Prior to working in Moyola, I had limited experience in dealing with challenging behaviours so I was shocked that the behaviours were accepted by staff in Moyola. 10:19
It was common at times for staff to ask one another, 'did you report an incident?' And the response was almost always 'what is the point, nothing is going to be done about it'.

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I spoke to my family and friends to help me process the stress of working in these conditions. I did not feel supported by senior staff. I accepted that this was the working culture. Over time, I became what I would say looking back, institutionalised and believed that 10:20
there was no benefit to reporting incidents or being upset about them as there was nothing that could be done.

For the first seven months I assisted colleagues in 10:20
other group rooms. I was then allocated a room along with H724 who was also a day care worker. We were allocated a room of 10 to 12 patients who I would describe as having a higher ability and less personal care needs than other patients. It was rare to have 10:20
new patients join the group so most were long-term patients. One patient was there 40 years and another patient was there for 30 years. The group was of a mixed age range and were male and female. Support

staff from the ward brought patients to Moyola in the morning and I brought them back at the end of the day. When handing over patients I would provide a verbal update on the type of day the patient had to auxiliaries or nurses who were to bring the patients back onto the ward. There was no formal handover note exchanged. It was the responsibility of the staff member to read the patient file and ask questions if they wanted to know move, particularly in relation to risks associated with the patient. For example, when a new patient attended Moyola, a senior staff member were verbally provide an overview of the patient's needs. To find out more about the patient I rang the ward they were admitted to and asked any questions. For existing clients there were files in a filing cabinet in the room where they spent their day. If a patient seemed out of sorts, I would ring the ward and speak to staff to be told that the patient had a bad night or had been administered PRN.

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There were times I was told that PRN had been administered to help the patient's mood or if they were unsettled. I did not administer PRN to patients. I if I did not ask these questions I would not have known about the patient's current mood. I do not know why some ward staff did not volunteer this information on handover. It may have been because they were not aware they had to or they may have worried that day care staff would not permit the patient to attend if they

10:22

knew an incident had occurred on the ward. As the burden to find out additional information about patients fell to the individual, I did not know if other members took steps I did to find out what they needed to know to care for the patient appropriately. 10:23

As H724 and I were both care workers, we did not require a care assistant to work with us every day. On occasions when a care assistant was allocated to our room, I delegated tasks such as taking the patient to 10:23 the toilet, making tea and coffee and getting things that were needed for activities. I did not work with nurses.

Restraint using MAPA techniques was used weekly in 10:23 Moyola. I was not trained in MAPA for a few months after I started in Moyola. Where MAPA restraint is required the staff member who requires help raised the alarm. Prior to my training I witnessed a number of MAPA restraints but I could not help my colleagues 10:23 which I found frustrating. When I was allocated my room with H724 we had to carry out MAPA restraint once or twice a month. I recall one patient called P98 where MAPA had to be used. She is still a resident in MAH. She was very strong and was punching, kicking, 10:24 biting and scratching other patients and staff. Five staff had to restrain her as she often broke free from the restraint. She would eventually calm down after she was restrained. Restraint was only used where

verbal calming measures did not work. Sometimes patients would throw things so I ensured that all patients and staff were safely moved to another room.

MAPA incidents were reported on a specific form and submitted to H722 and the nurse in charge of the ward that the patient was admitted to. When I first joined Moyola I do not think that there were separate MAPA forms to be completed. It was accepted that these incidents were to be reported. 10:24 10:25

As all staff in Moyola were MAPA trained, this meant that any incident could be dealt with quickly and in the safest way possible. There was a female patient who did not like to lie on the floor as it would cause her to have flashbacks to an experience that upset her. When MAPA was used to restrain her, staff tried to sit on a sofa to avoid the ground to ensure that she was not upset further. 10:25 10:25

I am aware that there were seclusion rooms on Cranfield 2, however there were no seclusion rooms in Moyola. If a patient was throwing things or hitting out but it was not appropriate to use MAPA restraint, they were sometimes given space in a room by themselves to help them settle. 10:25

As a number of my colleagues were related to staff working on wards they would often talk about things

that happened on wards with one another. These conversations would be held in communal areas where patients and staff could overhear them talking. For example, they would say 'did you hear what patient did?' I thought this was inappropriate as they were talking about confidential matters that they would not have known about only their family member told them. I was of the view that I did not need to hear gossip about patients. There were times however, that I would find out more about a patient in my room than I did at hand over. 10:26 10:26

I did not witness any abuse at Moyola, although some staff members were more abrupt than I was to patients. They provided a good standard of care to them. The atmosphere in Moyola generally remained the same whichever staff were on. Most of the patients were non-verbal so I read their reactions based on their body language. I did not see a negative change in any patient behaviour when staff entered the room. 10:26 10:26

I am not aware of any inspections taking place during my time at Moyola. I was not aware of any oversight or inspections from representatives from the Belfast Trust. If any reviews or inspections of Moyola were carried out, they were done by the management staff in the day care centre, usually H722 and H77. This meant that the reviews were not independent. I cannot recall an auditor carrying out a walk around inspection or 10:27

speaking to staff. I do not believe that there was an annual review of staff and I cannot recall any team meetings or individual review meetings during my time in MAH. The culture was to speak to a manager if I needed guidance or support. As previously stated, this support was conditional based on what issue was raised. I cannot recall with certainty whether there was any CCTV recording in progress on the Moyola ward between 2008 and 2010. 10:27

I left MAH on the 26th April 2010 and took up a position as a day care worker with another health and social care trust..." 10:28

Which you name. 10:28

"I remain in this position today. I am based in a training and Resource Centre..."

And you say its name and where it is located. 10:28

"The reason I left MAH was because I felt it was a very difficult and stressful job for which I did not receive support. The challenging behaviour was frequent and I struggled to cope with these behaviours. The job in..." 10:28

And you name the resource centre.

"... was the same job with the same pay but I would be working with less challenging clients. I have not come across any former patients of MAH in the..."

Resource centre that you name. 10:28

"When I entered private care I found it difficult to adapt to the structure. My working day was not as structured as in MAH. The day was set so that activities would take place at set times. In the 10:29
community times for activities were more fluid and there was discussion around choices available to service users and freedom of movement. Patients in MAH were supervised at all times and were usually confined to the room they had been allocated to. There was more 10:29
freedom of movement in the community.

I rarely experienced untoward events or had to use MAPA. As MAPA restraint was not needed as much in the community not all staff are trained in it, whereas all 10:29
staff in MAH were trained which gave me some comfort when assisting patients with challenging behaviours. Due to staff shortages there are occasions when I work in..."

10:30

And you name an adult resource centre.

"... and have supported former patients of MAH. I am aware that after the allegations of abuse were made

public a lot of staff left MAH which led to a shortage of staff. The South Eastern Health and Social Care Trust sent out an e-mail to current staff asking for volunteers to help out in MAH. As I was previously in MAH I felt that I could offer support required. I volunteered and was placed in MAH from July 2022 to December 2022. I was the only person from my local area who volunteered to go to MAH. My family and friends thought I was wrong to go back to MAH because of the allegations and CCTV footage. I wanted to help the patients and was not concerned about the CCTV as I would never hurt my patients. 10:30 10:30

Although my time in Moyola was not great, I learned a lot from the experience and I welcomed the experience of working on the wards. I was placed on Cranfield 2. I attended an induction and was supervised by the ward nurse who discussed where I would be working when I started each shift. I noticed that most of the staff were agency staff from other countries, along with some staff from the Trusts. The level of care on the wards was brilliant. Staff treated patients with dignity and respect and did as much as they could for patients. Staff did not talk about patients in inappropriate settings. I wondered if this was because staff were from different cultures and had a different attitude and approach towards providing care for vulnerable people. 10:31 10:31 10:31

If an untoward event occurred on Cranfield 2, there was a procedure in place for reporting it. This was a contrast to my experience in Moyola. I was not responsible for recording incidents or updating patient records but I noticed that the nurses on Cranfield 2 were completing records. I did not experience any untoward events, however if a patient had hit out and I had not immediately reported, I was approached by a senior member of staff who asked me questions to gather information on what happened. This is a significant change in culture. So much so, that if someone did not directly report an incident someone else would mention it to senior staff who would follow up with the individual. 10:32 10:32

I felt that the staff took no shortcuts when it came to patient care. For example, where a patient needed two members of staff to go somewhere, they had to wait until two people were available. They did not take the risk in allowing one person to bring the patient alone which is in contrast to the practice in Moyola. 10:33

I finished in MAH in December 2022 and I was given an opportunity to specialise in mental health in two hospitals..." 10:33

That you name.

"...working bank shifts. This is a new learning

opportunity for me which I really enjoy.

Looking back on my time in MAH I feel that I learned a lot and gained a lot of experience working in the field of learning disability. This has helped me progress my career as a care worker. Working with patients with challenging behaviours was very difficult. From my experience, the fact that staff were related to each other did have an impact on the culture within MAH. I had a general feeling of unease at the lack of oversight on the running of MAH. My experience reaffirmed my belief that no-one really knows what goes on in there as there was no transparency and that what happens at MAH stays at MAH." 10:33 10:33

10:34

Phillip, that's the end of your statement and you then go on in the final pages to give the declaration of truth and sign your statement?

A. Okay.

3 Q. And there are no exhibits to your statement. Now, before I have you adopt your statement I think there are two points that we discussed you wanted to clarify? 10:34

A. Yes.

4 Q. Okay, so the first is at paragraph 1 and paragraph 23 of the statement you referred to working in the South Eastern Health and Social Care Trust. Just to confirm, I think you've actually said to us that you worked within the Belfast Trust at MAH but that your funding was through the South Eastern Trust? 10:34

A. Yes, my current job is with the South Eastern Trust however, when they were seeking assistance from, or the Belfast Trust were seeking assistance from existing staff members, they recouped the funding from the Belfast Trust to pay the South Eastern Trust's staff who were assisting.

5 Q. That's fine, all right thank you, sorry to cut you off there, that is fine, thank you Phillip. The second point is that at paragraph 22, which is at page 11 of the statement, the second word at the top of the page reads "private" and it should actually refer to patients going into the community? 10:35

A. Yes.

CHAIRPERSON: It should say community care?

6 Q. MS. BERGIN: Community rather than private care, yes. Thank you, Chair. Phillip, other than those clarifications are you content that the statement is accurate first of all? 10:35

A. I am content.

7 Q. And you wish to adopt it as your evidence to the Inquiry? 10:35

A. I wish to adopt it, yes.

8 Q. All right, I am going to now move on to ask you some questions?

A. Okay. 10:36

9 Q. You have the cipher list in front of you. We will keep an eye on time and, subject to the Chair, if you need to take a break certainly please do indicate?

CHAIRPERSON: We normally stop after about an hour, if

you keep going for 20 minutes or so and we will see how we do.

10 Q. MS. BERGIN: Yes, thank you, Chair. So, Phillip, you worked in Muckamore during two time periods. You were in Moyola Day Care Centre as a day care worker for just over two years between 2008 and 2010? 10:36

A. Correct.

11 Q. And then 12 years later you returned to Muckamore for five months between July and December 2022 and at that stage you were on a ward Cranfield 2? 10:36

A. Yes, that's correct.

12 Q. I'm going to start by asking you about your experiences as a day care worker at Moyola and to begin with, it maybe obvious to you but I think it would be helpful if you could explain for the Panel what a day care worker 10:36 does in the Muckamore day care centre setting, just briefly?

A. Essentially we would support the patients when they leave the ward and attend the day care settings for during the day activities that they could participate 10:37 in. They would be allocated a group room to be supported by designated staff and that would be the format of a day care worker who would oversee the group and who would have an allocated member of staff normally and you would have the same patients that 10:37 would attend.

13 Q. Apologies, I am going to interrupt you for the exact reason that the Chair helpfully reminded me too also which is the stenographer is trying to take a note of

the evidence so if you can just go, and I am trying also to go as slowly as possible, that would be of great assistance to the Inquiry okay. So, in terms of then when you started at Moyola, you said in your statement that you spent the first seven months assisting colleagues in other rooms?

A. Correct.

14 Q. And you have indicated that you had some further training when you first attended Moyola, health and safety and that sort of thing. During those first seven months, was that some sort of a supervision or a broader training or probation period, can you explain that period of time please? 10:38

A. That period of time I was, after the successful job interview, I assumed myself that I would be given a room because if you are a day care worker you are given a room to look after. That did not happen. I asked management why I did not have a room and the answer was you're covering a maternity leave and in the meantime there's a lot of staff at times could be off, could you help out in helping out in different rooms for a number of -- for a period of time. That actually ended up being several months. 10:38 10:39

15 Q. Okay, sorry --

A. Then after that I re-requested a room and I was given a room with another day care worker, so it was two of us. 10:39

16 Q. So that first set of months, I suppose during that period, we've talked about training, was there any further specific training in terms of managing patients

or behaviour that you can recall?

A. Not that I can recall.

17 Q. Okay. I want to ask you now about the staffing at Moyola day centre in terms of us getting a picture of that and you've described Moyola as busy with a lot of staff and patients. I appreciate it may be very difficult to remember specifics but can you give us a rough idea of how many staff would have been in Moyola on a daily basis? 10:39

A. Roughly I would say about seven group rooms each with approximately an average ten patients with two staff. 10:40

18 Q. And so if I can just stop you there, in terms of the types of staff, so there's a manager of Moyola and then you've referred in your evidence to line managers?

A. Yes. 10:40

19 Q. And I suppose can you talk us through the types of staff, the different disciplines of staff that would be present at Moyola on a given day?

A. Yes, in the day care room there would be a day care worker and a care assistant. Above that were based senior day care worker also known as manager in my reference. So that would be a senior day care worker in the office. And above that would be Day Care Operations Manager, that would be the next level of management. 10:40 10:40

20 Q. And you said in your statement that you didn't work with nurses. Were there any other specialisms in terms of specific therapeutic staff or medical staff who would have been in and out of Moyola regularly or not?

A. There was a therapeutic art therapist that would visit once a week to our group room. Also some guidance and advice given by behavioural therapy team members.

21 Q. Okay. And you said about groups, so patients being allocated different rooms and groups. In terms of staff allocation, was it the case that staff generally had their room and their group or you've described obviously an experience where you moved around a lot, but would it generally be the case that staff -- 10:41

A. Yes. 10:41

22 Q. Were allocated to specific patient groups?

A. That's correct.

23 Q. And in terms of then, you had referred to care assistants, can you explain I suppose one of the things in your statement that you said was that because you 10:42 and your colleague, who were both care workers, were assigned together to a room, you didn't need a care assistant. Can you explain I suppose the difference in terms of care workers and care assistants' roles in Moyola? 10:42

A. Sorry, to provide a bit more clarity, whenever I refer to care worker, that's quite a generic term. That's probably better said as day care worker as we were both higher than care assistants, it was seen as there was already two staff in the room and we had a larger group 10:42 and with regards to the ratio of staff that is enough for your staff group room so you're not assigned a care assistant as well. Sometimes you did, sometimes you did not. Other rooms would generally be a day care

worker plus a care assistant.

24 Q. In terms of the assignment of day care workers and day assistants to the rooms, how were staff assigned or how were the numbers of staff assigned? For example, was that based on the numbers of patients in a group, was that based on the types of complexity of the patient's particular needs, how was it allocated in terms of staff numbers per room? 10:43

A. Day care workers did not have a say on that, it would be management would dictate that. 10:43

25 Q. Okay. And in terms of the numbers then you'd said I think it was two would have been enough?

A. Yes.

26 Q. Did the level of staffing fluctuate based on the attendance of patients per day or was there a set? For example, if you turned up and there were fewer patients than generally attended would the staff remain there then throughout? 10:43

A. To a large degree it would remain the same.

27 Q. Okay and in terms of then you describing Moyola as busy with staff and patients, in terms of these groups of patients, how many patients would be attending Moyola on a daily basis? 10:44

A. It's very hard to recall, but 50 probably.

28 Q. 50 okay. Apologies for cutting across you there. I was going to say you've given the example that when you were allocated your own room you had a group of between 10 to 12 patients? 10:44

A. Correct.

29 Q. Would that have been a typical size of a room group?
A. Slightly larger than normal.
30 Q. Okay, thank you. And in terms of who, or I suppose which patients attended day care and which groups the patients were allocated to, can you tell us anything about that? 10:44
A. That would be decided by management and you were just basically told.
31 Q. Okay. In terms of then the frequency of patients attending, is that something that you can tell us, so for example, was it the case that the patients in your groups would attend Monday to Friday or would they only attend on certain days or could they drop in and out when suited them? 10:45
A. For most part, most patients attended each and every day, morning and afternoon. 10:45
32 Q. Okay. And in terms of then you've described working with a range of patients in your group, so in terms of age, in terms of being non-verbal or higher ability patients, can you I suppose tell us more about your experience with your group of patients? You've said they were higher ability compared to when you were working in other group rooms during the first seven months. How did those experiences compare in terms of the activities with patients? 10:45 10:46
A. In our group, as I've said before, they were more able in terms of, they had little personal care needs. They could articulate their needs and wishes. There was a good range of abilities. They could interact with each

other quite often and with staff. They were higher ability as we would refer.

33 Q. Okay. And so just in terms of the patients then attending your room or your group, the same patients essentially attended in the same group every day? 10:46

A. Correct.

34 Q. Yes, and then in terms of what the patients actually did during their time in terms of enrichment or learning or stimulation, you've said that a normal day in Moyola was very structured with activities set out 10:46 on a timetable and that patients were there, I suppose, in the morning and afternoon but would return to the ward for lunch. In terms of the types of activities, who was responsible for planning that set timetable of activities? 10:47

A. That would be the responsibility of the day care worker.

35 Q. Okay, and so did you have, in terms of your role in that, could you provide us with a bit more information about that? 10:47

A. Based on their likes and dislikes and based on if they have previous experience in day care, we could build up a picture of how a suitable day care plan could be initiated for the patient. However, it also needed to link in with what the timetable would be generically 10:47 for the group room. So, in one sense, there was personal choice, but at the same time we had a structure that this is our generic timetable and we try to marry the two as best as possible.

36 Q. Okay. In terms of then I suppose if I put it in this way, when you describe planning the timetable, in terms of the content of the activities so, for example, you've described different learning or play activities, was it the case that you essentially were I suppose coming up with those activities or was it that there were set activities that you could choose from? 10:48

A. We had our limited resources that we could come up with but it would be my responsibility and my colleague to come up with the activity choices for the patients. 10:48

37 Q. And did any, in terms of you coming up with the timetable of activities, did you have any input from the senior day centre workers that you've referred to, or any of the therapeutic services, did they input that into your planning in terms of what patients were able to do or what would best suit them? 10:49

A. Things such as art therapy, we would offer that to all patients if they would like to, because we thought it was excellent. In terms of other activities such as going to the swimming pool, obviously who would wish to participate in that, we would encourage all to participate. In terms of our direction of how it is developed, that would mostly be the day care worker would need to come up with those ideas. 10:49

38 Q. So was it yourself and your colleagues? 10:49

A. Yes.

39 Q. That then facilitated all of the activities apart from you have referred to an art therapist?

A. Yes.

40 Q. Okay and one of the things that you have said that you did during I suppose your interactions with the patients, was that you recorded their levels of interaction and progress and you assessed if they needed further assistance with learning and development. So I wonder can you tell us a bit about what, in terms of assessing learning and development, what was the assessment tool or what learning and development were you assessing essentially? 10:50

A. How their mood was with staff and with other patients, assessing their levels of enjoyment of the activities that they were taking part in and also assessing, for example, if something happens on the ward and they were then in day care and assessing has that changed, for example, in most cases it would be mood. For example, if our activity that we offered, they found it beneficial and they were in better behaviour or mood afterwards, we could give a good report. 10:50 10:50

41 Q. So, would it be fair to say, and I'll I suppose describe this to you and you can hopefully confirm if it's right or not. Was it the case that then, you know, in terms of assessing progress or learning if a patient, for example, on a certain day had an art activity and they seemed to not really engage with it but then the following day they really enjoyed it and then they kept engaging with it and then they built up a habit or pattern of engaging and learning new skills with holding the brushes or whatever the case may be, that's the type of thing you would be assessing and 10:51 10:51

recording. Or would it be, for example, that you would have some sort of an assessment tool or a checklist from therapeutic services to check if patients were meeting any sort of progress?

A. To a large degree it would be both. 10:52

42 Q. Okay?

A. But with regards to assessing, it would be quite informal in nature.

43 Q. Apologies for cutting across you, whenever you say assessing, was there any sort of tool that you had to, 10:52 in terms of a checklist or anything or was it more informal than that?

A. No.

44 Q. Apologies, I cut across you there?

A. No, it would be quite informal in nature. No set tool 10:52 as such to follow.

45 Q. You have, in your statement, I suppose, contrasted your experiences working as a day care worker in Moyola and as a day care worker in the community. And, in particular, you've described that in the community your 10:52 experience was that patients had a lot more, I suppose, choices or autonomy around activities and it was less structured whereas in Moyola it was more structured and patients were supervised at all times and usually confined to the one room. Can you, I suppose, provide 10:53 any insight into why you think or any reasons you think it was more structured and supervised in Moyola than in the community? For example, was that something to do with the patients' level of need or was it to do with

staffing or resource issues?

A. Whenever I moved out to the community from MAH I found the transition very difficult and management in the community spoke to me two or three times and said Phillip, you need to relax, things are a lot more free flowing here and it is not as structured as it was previously in your old job.

46 Q. Why do you think that was in terms of the difference in approach in the community versus in Moyola?

A. It felt a lot less stricter. 10:54

47 Q. Okay, okay. I want to ask you now about communication between Moyola staff and ward staff?

A. Okay.

48 Q. And also about record keeping. So to begin with you've said that in the morning there was a handover to Moyola by ward staff. If we deal with this in two sections, existing patients and then new patients, okay. So in relation to existing patients, you have said that existing patients had day centre patient files and it was the responsibility of individual staff members to read a patient's file and if they had questions or wanted to know more, particularly around risks, then that was something that you have described phoning a ward or making your own inquiries about. Whenever you say it was the responsibility of the individual member of staff to make those inquiries, is that something that you were told to do or that you witnessed other staff do during the first seven months, or is that something you just, I suppose, took of your own

initiative?

A. It would be something that I took of my own initiative. Some points did not give clarity so I wished to want to know more information to get a better understanding, but that would be my own initiative. So I would phone the ward and try to ascertain the extra information that I wanted to satisfy myself.

49 Q. Okay, then you've said at paragraph 10 that there was a duty on other staff to tell Moyola staff of any new risks involving a patient. In terms of that duty, was there any sort of formal policy or instruction to you or to staff that they had to pass on information about risks in a certain way? 10:55

A. Not that I know of from the ward perspective. However, I took it personally as common-sense, if something that should be passed on, it should be passed on. And it sometimes surprised us that when we did inquire about some patients, for example behaviours, then when we inquired about it then we were given extra information which we were not told beforehand. 10:56

50 Q. CHAIRPERSON: Could I, I'm sorry to interrupt, could I just ask about this. It's the normal culture I believe in most hospitals for there to be a handover from one shift to another so that the incoming shift will get information about what happened overnight or on the previous shift. Is that your normal experience or not? 10:56

A. It would be but what I refer to is extra information that I'm not sure of, you know. But yes, there would be a handover from me to the ward and the ward to day

care.

51 Q. CHAIRPERSON: Was that happening naturally or --

A. It was.

52 Q. CHAIRPERSON: Were you having to seek it?

A. It was naturally, yes. 10:57

53 Q. CHAIRPERSON: So you were getting the handover?

A. I was.

54 Q. CHAIRPERSON: But then you were seeking further information?

A. Yes, as well, on the odd occasion. 10:57

CHAIRPERSON: Yeah, okay. Sorry to interrupt.

55 Q. MS. BERGIN: No, thank you Chair. So in terms of further information that you found out when you phoned a ward, for example, and I think in your statement you've said that you might have been told that a 10:57 patient had a bad night or had PRN administered before coming over, you've said that you don't know why some staff volunteered information, more information at handovers than others and that it may have been that staff, ward staff were worried that if they told you 10:57 about an incident that then the patient wouldn't be allowed or able to attend the day care centre. In your experience were you able to, I suppose, refuse a patient admission to day care centre or was anybody in the day centre able to do that? 10:58

A. On very rare occasion, on very rare occasion. It was frowned upon. If you had a time in day care you were provided for it and so you would be very reluctant to return a patient to the ward.

56 Q. What types of instances then would a patient be, I suppose, refused admittance to a ward or returned to a ward?

A. If they were displaying challenging behaviour, usually involving a MAPA situation, to something more extreme than other MAPA situations and we couldn't manage the situation without additional help. 10:58

57 Q. Okay. I am conscious of the time, Chair?

CHAIRPERSON: We could certainly take a short break now. Do you have any idea how much longer? 10:59

MS. BERGIN: We've still got a little way to go I think that merits a break.

CHAIRPERSON: Absolutely fine, okay, we'll take a break until about a quarter past and you'll be looked after and we'll see you back in 15 minutes, thank you very much indeed. 10:59

THE HEARING ADJOURNED FOR A SHORT PERIOD.

THE HEARING RESUMED AS FOLLOWS: 11:16

CHAIRPERSON: Thank you.

58 Q. MS. BERGIN: Yes, thank you, Chair. So, Phillip, we were just dealing with handovers in relation to staff, existing staff who were known to day centre staff. I want to now talk about new patients. So you've said when a new patient attended Moyola a senior staff member would provide a verbal overview of the patient's needs. When you say a senior staff member, do you mean 11:16

within Moyola or do you mean someone from a ward for example?

A. That would be the senior day care worker.

59 Q. Okay. And how, in terms of sharing of that information, was it just a verbal update or was that recorded so that all of the staff working with that patient would be able to access that information? 11:17

A. It would be a verbal handover and, from memory, there would usually be a form that she would have got filled out in conjunction with the ward to give to me. 11:17

60 Q. And we've heard about there being a specific day care centre folder per patient?

A. Correct.

61 Q. So then if a new patient was handed over to Moyola for the first time or brought to Moyola for the first time, who would be responsible then for creating that file and inputting that information into the file? 11:17

A. It would be myself, the day care worker.

62 Q. And in terms of then afternoon handovers, so when you or your colleagues brought patients back to the wards, you had said that you would provide a verbal update in terms of handover and, again, in terms of that duty you talked about before, was there any sort of formal procedure from your side of things in terms of making sure you provided information back to the wards every day? 11:18

A. It was just not that I know of a formal, however, that's just what we all did with each other, we provided a verbal handover.

63 Q. Okay. When you say you all did, would it have been your experience that your colleagues would also have been doing the same?

A. It would be my experience, yes.

64 Q. Okay. I want to now move on to ask you about records and how information about patients was shared between departments in terms of written records. So, we've talked about there being a day care file for every patient and that was a physical file stored in the room that the patient was allocated to? 11:18 11:19

A. Correct.

65 Q. So that the staff who were dealing with that patient could access information about them. And some of the things that you've said are included in that file would be the unsettled behaviours or learned behaviours. In terms of, I think what you've said in your statement is that the particular parts of those behaviours wouldn't be recorded because you would know what those behaviours were, but did you record, for example, in those files any sort of updates in terms of if a patient had unsettled behaviour but, for example, the frequency of that unsettled behaviour increased significantly or decreased, is that something that you would then have cause to go back and update the file about? 11:19 11:19 11:19

A. Yes, we would be doing daily notes and so that be would reflected in our daily notes, that information.

66 Q. Okay, so then within the file then we then have the daily notes and the daily notes are handwritten notes?

A. They are.

67 Q. That were completed every day?

A. Correct.

68 Q. And placed on each patient's file?

A. Correct. 11:20

69 Q. You've said that would include, for example, if there was an adverse incident in terms of a patient requiring restraint or just your assessment as to the patient's progress on a given day?

A. Correct. 11:20

70 Q. And in terms of who had responsibility for completing those forms, if there was you and another colleague in the room, did you always, I suppose did you divide it up so you always completed it for the same patients or did you both have input into the daily form? 11:20

A. It would be, we would have allocated patients to look after, however, if my colleague was off, for example, I would complete all their notes and likewise she would do my notes. Sometimes we would ask the staff assisting us to complete notes but generally, 99% of 11:20 the time it would be the day care worker who would be responsible.

71 Q. In terms of those being daily reports, in practice were they done daily and did anyone check that they were being done daily? 11:21

A. Not that I recall that they were checked as such, there would be a quarterly report that would be passed on to management.

72 Q. Yes. In terms then of, I suppose, the daily reports

feeding into the quarterly reports, one of the things that you had said was about unsettled behaviours and how really only the staff members who worked with the patients every day and who recorded those unsettled behaviours would know what the unsettled behaviours were for a particular patient?

A. Correct.

73 Q. And those wouldn't then be recorded on the daily reports, it would just be recorded as unsettled behaviour, it wouldn't specify what those were? 11:22

A. Yes, so the unsettled behaviour terminology, which would be quite often used as said in the statement, purposely vague, it would just refer people to what their normal kind of unsettled behaviours would be which might be highlighted on a separate sheet. 11:22 However, if there was new behaviours, that would definitely be flagged up.

74 Q. And then in terms of then people, other people who were reading those daily reports understanding what that meant, so, you had said that the purpose or one of the 11:22 purposes of completing the daily and quarterly reports is to feed into information available to those who were creating the patient's care or behavioural plans?

A. Yes.

75 Q. So how was it communicated to them if they, how did 11:22 know what a patient's unsettled behaviours were? Was that retained, a list of unsettled behaviours retained in the main file or shared with them or how was that information shared?

A. I don't know what the ward records were, in terms of what their record of unsettled behaviour. However, if, for example, a patient had three typical behaviours that was given when they were already with us in day care, I would have assumed when they left the ward or at the start of day care, our senior day care worker would have attained that information. So I knew then that information, so I didn't need to repeat it back to them each and every day. 11:23

76 Q. Yes. And another type of document then you've referred to is an incident report. When you refer to an incident report do you mean the daily report were you then include details of incidents or do you mean there was at some point a specific incident report? 11:23

A. There was an incident report. The terminology has changed over the last number of years. It was, in those days, referred to as an incident report, also known as accident report form. That would be a large document that would need to be completed giving very specific details of the incident and that would be given to different parties, to senior management, to the ward and also day care. I think, upon reflection there was, it made out three copies and you gave a copy to each party. 11:24

77 Q. And would that be a separate type of document to, for example, a specific document where you had to record the use of restraint or MAPA, would that be different to that or are those the same documents we are talking about? 11:24

A. From memory initially it was just incident reporting document. When MAPA forms were involved I think there was an extra document for MAPA. Now, when that started, I can't recall, but that was a new practice for care workers to start to complete in addition. 11:25

78 Q. Okay. And then I suppose in terms of the final set of documents then is the quarterly report. What I want to ask you about that is you have said that that was somewhere that you recorded, I suppose, a broader overview rather than the daily, it was a broader 11:25 progress report. And you had said that, you know, you would state if behavioural support was required. When you say you were stating if support was required, was that you essentially signposting then for the quarterly report if you thought any extra support was required 11:25 for other professionals for the multidisciplinary meetings?

A. It was an opportunity for me to pass on to my line manager, i.e. the senior day care worker. To request additional assistance. Now, if that is therapeutic in 11:26 some way or guidance from ward or medical means, that was my opportunity to do that. It was a summary, in essence, of how they had been over the last number of months.

79 Q. Okay. And you refer to attending MDT meetings. Did 11:26 you attend those for every patient in your group or, again, was that divided between you and your colleague in the room?

A. It would be divided.

80 Q. And how often did you attend those or did they occur?
A. Generally it would be annually.
81 Q. Okay. And one of the, I suppose, comments that you've made is that you felt that you were, I suppose, ignored by the medical staff at those meetings. In terms of I suppose your input to those meetings, were your quarterly reports, were they part of those meetings or were they on the agenda at those meetings? 11:27
A. The quarterly reports wouldn't be, as such, as part of those meetings, I would also have my own day care review notes I would take to these meetings and I would put forward. 11:27
82 Q. So you had the opportunity then at the MDT meetings to, I suppose, work through the agenda and speak out about different issues? 11:27
A. Yes, I would talk about how things are getting on at day care.
83 Q. And, I suppose, in terms of why you say you felt ignored, do you want to explain that a bit, please?
A. Just from my academic learning and from just, I thought it would be, we all have equal parties to this person's support whilst they are staying in Muckamore. I just felt that each and every time I did make some comments, I felt personally there was not much comment in the group about day care. It just seemed to be talking, focusing on how things are on the ward or medical issues and there was very little question and answers to me. So I did feel a wee bit out of place. 11:27 11:28
84 Q. Okay. I want to move on now to patient supervision and

you had said that if a patient needed one to one supervision for attending at the swimming pool for example, that was provided. Who assessed whether a patient needed one to one supervision like that?

A. It would be a male member of staff with male patients and a female member of staff with the females. It wouldn't be necessarily be, as such, one to one. However if there was a patient needed, you know, close supervision in terms of additional support, especially in a pool setting, you would, you know, be beside them, but you're not -- it's how you term as one to one but it would just be staying close to them, making sure they are okay whereas other patients may be more able in the pool to, you know, enjoy the therapeutic benefits. 11:29

85 Q. So that's something that you, I suppose, in practice then assessed as you worked with patients; would that be correct?

A. Correct, yes.

86 Q. And you've also said if you took patients on day trips then you would have been made aware of any swallowing guidelines. Now, were you trained in relation to any sort of specific supervision for swallowing and for patients with those types of needs?

A. To be quite honest I can't recall but I would assume I was. How that was formally done in those days, I can't recall. It is very much ingrained in how we do things nowadays and we are very strict regarding that practice, especially swallow guidelines. 11:30

87 Q. I appreciate you have said it's quite some time ago, but can you recall, and if you can't please just say so, was it that everyone, I suppose in terms of day care centre staff or everyone on the excursion would have been informed somehow that the patient had a specific swallowing guideline or would there have been just one person who was responsible for that?

A. I can definitely remember it was a lot of verbal passing on of information and it would be my responsibility to pass that on to someone who was assisting me that has never been in my group. I would pass on verbal guidance, if necessary.

88 Q. And in terms of then, I suppose, the patients that you dealt with ordinarily, I mean were you dealing with patients who had those sorts of swallowing guideline requirements, regularly? You've said often patients had, for example, biscuits and tea or coffee, so?

A. Yes, going from memory my group were quite able and it could be a case of in my group there was no patients that required swallow guidelines. That is probably quite highly likely. As I do not recall any patients needing additional support regarding their swallowing, you know, when we offered the teas, coffees or snacks, they were all able to eat and drink quite independently with no assistance needed.

89 Q. Then moving on to patients that were deemed high risk, who you said there was a policy that staff should not be left alone with them. Was there any sort of formal, written policy that you can recall or was it more a

matter of practice?

A. It was more a matter of practice and word of mouth.

90 Q. And in terms of then supervising or managing those high risk patients, did you have any specific training in relation to that when you went to Moyola? 11:32

A. No specific training, as such, just word of mouth.

91 Q. In terms of how a patient was, I suppose, categorised as high risk, is that something that you were told about or is that something that you, as a centre, determined? 11:32

A. A lot of the communication at Muckamore is by word of mouth and it is important to share that information with your colleagues. That was very, very, a lot of information was given by word of mouth.

92 Q. Okay, in terms of then, you said you didn't think there were a lot of patients, from memory, that had I suppose swallowing needs. In terms of the proportion of patients that you were dealing with generally, were a lot of those high needs or would there have only been a few high risk, sorry, patients? 11:33

A. How do you mean by high risk?

93 Q. One of the things you have referred to is that you weren't allowed to be or you weren't meant to be left alone with a high risk patient in terms of patients who had, I suppose, the propensity to injure staff or other patients, in terms of the patients that you generally dealt with in the day centre, were you dealing with high risk patients a lot? 11:33

A. There was a few that would be deemed as high risk.

94 Q. Okay?
A. Yes.
95 Q. And you've referred specifically to two incidents where you were left alone with high risk patients, one when you were punched and one when you were locked in a room and had things thrown at you. In terms of how that policy or, I suppose, practice was operated, what sorts of things did you do practically to make sure that staff weren't left alone? 11:34
A. It was a shortcoming on my part and my colleagues to allow those circumstances to happen. I think, you know, in an incident involving the recreation hall where I was threatened, we assumed that the trainee was in good form and the trainee or the patient just took an umbrage for an unknown reason, a possible opportunity to attack staff. In the other circumstance when the other patient arrived at day care it was very early in the morning and it was possibly a transitional issue the patient struggled with and I happened to be the person that was covering that group. I assume that patient was not happy about it and took the opportunity to attack me. 11:34 11:35 11:35
96 Q. In terms of both of those incidents, you've said that in both instances you didn't use your personal alarm and in the first instance you said that you didn't use it because it was so early in the morning that you didn't think other staff would be available or there. Can you explain a bit more about why you didn't think that they would be able to respond or there would be 11:35

nobody to respond?

A. I think that's more of an afterthought. It happened so quickly, they walked in and they immediately attacked me and I ran out. It possibly, looking back, it would have been better to set off the alarm and then also try to leave the room. 11:36

97 Q. No, that's fine. Then the second then incident, I just wanted to ask you about it because you had said that you didn't use your personal alarm on the second occasion which was in the recreational hall because it was too far away. Whenever you say too far away, if you can help us understand, do you mean that physically the alarm was out of range or do you mean that there wouldn't have been time for somebody to come and assist you? 11:36

A. No, the nature of the different buildings at Muckamore, it is not there anymore, however there was a recreational hall as we would refer to and it was not connected to the system, the electronic system of the personal alarms which were for use at wards and day care. 11:37

98 Q. All right, thank you. And I want to now ask you about your experiences with restraint and seclusion?

A. Okay.

99 Q. So we'll start with seclusion and you've said that during your time in Moyola there were no seclusion rooms but you've said that sometimes if a patient needed maybe to settle they would be left in a room and sort of given space by themselves. Were they brought 11:37

into another room or was it that you would, everyone else would essentially leave the room?

A. It was essentially we would leave the room to protect other patients and, at times, protect the staff. And our opinion was that as long as we keep an eye on the patient, make sure they are okay, obviously if they need extra support we would go back into the room. We were not preventing them from leaving the room but if they wrecked the property, that's okay, that can be replaced but for safety we thought it was important to remove the other patients. 11:37 11:38

100 Q. So the patients were essentially monitored in those situations?

A. Monitored.

101 Q. And the door wasn't locked? 11:38

A. No, no, they would just be monitored.

102 Q. In terms of that happening, is that something that you use as a technique or that happened often or --

A. It was a rarity, it was a rarity. It's not something we would actively adopt. 11:38

103 Q. And is that the sort of circumstance that would be recorded then on the daily reports if that were to happen?

A. It would be, yes.

104 Q. And I just wanted to ask you briefly, and I know I am jumping around a bit because we are talking about Moyola, but just on the topic of seclusion, we're going to come to later your experiences in Cranfield 2, did you have any experience of seclusion techniques during 11:38

your time on Cranfield?

A. Recently whenever I worked there?

105 Q. Yes?

A. No.

106 Q. No. Sorry -- 11:39

A. No, no.

107 Q. That's very helpful, thank you. Going back then to restraint, you've said that you did MAPA restraint training during your first few months in Moyola. You said that it didn't occur at the very beginning for a 11:39 few months. Do you know why that was?

A. I think there is issue regarding getting trainers and there was already people booked in.

108 Q. By the time you were then allocated your own room or your own group after seven months, were you trained by 11:39 then?

A. Oh, yes.

109 Q. And in terms of any refresher training during those two years, I think you said that you thought you had one session, is that right, can you recall any others? 11:39

A. Yes, we would get a refresher training every year.

110 Q. Right okay?

A. Standard practice.

111 Q. You had said in terms of the frequency of restraint techniques being used on Moyola that they would have 11:40 occurred weekly and in your room in particular you and your colleague would have had to do them maybe once or twice a month?

A. Correct.

112 Q. In terms of initiating or deciding that a restraint procedure had to be adopted, who was able to make that decision, is that something that you as a care worker could decide to do?

A. It would be a decision that I could make alongside my colleague, we were both day care workers and we make a collective decision as to if it is needed. 11:40

113 Q. And in terms of then your training and then how that worked in practice, was that very much a matter of last resort if diversionary or verbal de-escalation techniques had been exhausted? 11:40

A. It would be.

114 Q. And you gave an example of a patient who had a particular, I suppose, issue with being restrained on the ground and that you adapted your techniques in terms of restraint to make sure you caused them less distress. Would, I suppose, the ability or the desirableness or appropriateness of restraining somebody is that something you would have had any input from, from ward staff or therapeutic services in terms of a certain approach to restraint tailored to certain patients? 11:41 11:41

A. From recollection it was by word of mouth. This was an experience this patient had had some time ago so if MAPA techniques were to be initiated, avoid as much as possible, if -- avoid going on to the ground because that would be very upsetting for the individual. We were able to support her, even through MAPA, but not go to the ground because that would be traumatic for her. 11:41

115 Q. So, were you able to, I suppose, in line with restraint training tailor that restraint to the needs of patients that you got to know?

A. Yes, yes.

116 Q. And in terms of the procedure for managing other patients, was that -- you've said that you would essentially, I suppose, get other patients and staff out of the room or out of the space, is that something that you were actually trained to do or was that just more a matter of initiative in terms of assessing the situation at the time? 11:42

A. It was initiative and word of mouth, just general way of doing things amongst staff, that's what we would talk about. But I didn't recall any training, as such, to kind of advise on that guidance. 11:42

117 Q. And after a patient had been restrained was there a procedure, or what was the practice that you followed in terms of, you know, dealing with the patient? Were they assessed by anyone, were they monitored?

A. They would be assessed and monitored by myself and my colleagues who are currently supporting them. 11:43

118 Q. And were patients ever injured during the use of restraint?

A. Not that I know of in terms of whenever I was doing MAPA. 11:43

119 Q. In terms of, you said earlier in your evidence to the Inquiry that in terms of patients being returned to wards --

A. Yes.

120 Q. So then when a restraint had been, a procedure had been used then a member of your team then would have notified the ward to let them know and then a patient, depending on the circumstances, would perhaps then be brought back to the ward. And in terms of then, we talked earlier about the use of specific restraint forms, before there was a specific restraint form was the use of restraint recorded somewhere? 11:43

A. That's a good question. If there was, if there was an intervention it would be recorded on the daily notes. When it actually started, the actual MAPA forms as such started, I can't recall exactly. If it was, it would be recorded obviously in daily notes and it would be recorded in the incident report form. They almost went hand in hand. If there was a MAPA or what we would refer to a restraint incident, it most likely would have been an incident as such, it is obviously significant in nature, it needs further, you know, consultation so it needs to be formalised in a more formal manner. 11:44 11:44

121 Q. When the actual restraint forms were brought in you would have completed those and then who would they have been sent to or circulated among?

A. They would have been sent to a senior day care worker.

122 Q. And in terms of then, I suppose, any review of the restraint, what had happened, any opportunities for lessons learned or was there any opportunity for that? 11:45

A. I don't recall any, you know.

123 Q. So after a restraint, for example, you sent off a form

and then was there, as a matter of course, a meeting then to discuss that or anything?

A. Sometimes, you had your senior day care worker come back to you and they would say, they would say some advice or some guidance or how they would have responded to what they heard about what happened yesterday, for example. 11:45

124 Q. I want to now discuss the issue of resettlement very briefly. Did you have any involvement in resettlement policies or procedures at Moyola? 11:46

A. Unfortunately not.

125 Q. And in terms of specifically, I know you said not, I just want to ask you this question; in terms of the activities that were done with patients, and we know that patients had different care plans, was it ever the case that any of the activities that were done with the patients in the day centre were tailored to assist them with their transition into the community? Was anything tailored in that way? 11:46

A. I can only speculate -- 11:46

126 Q. In your experience?

A. In my experience I could only speculate that what they did in day care was passed on to the resettlement parties.

127 Q. Okay. You have referred in your evidence to attending a meeting where a patient had returned to Muckamore after a community placement hadn't been successful. In terms of the patients that you worked with, was it common or not common that you would be working with 11:46

patients who would be coming back, that you would be seeing again having come back out of the community?

A. It wasn't common.

128 Q. And you've also told us about another meeting with a patient who was quite fearful about a resettlement into the community and that she was quite afraid about that. Were you aware of any types of professional advocacy services or supports that you could point patients to in relation to engaging with staff about resettlement? 11:47

A. No. 11:47

129 Q. No. So, for example, like Bryson House or Patient Client Council or Mencap?

A. No.

130 Q. In terms of staffing at Moyola, you've said that there were times that there were agency or bank staff, was that a regular occurrence? 11:47

A. A rarity.

131 Q. Rarely?

A. Very rarely.

132 Q. And when they were in Moyola would it be that they would be there, for example, days at a time or would they be there for longer periods, or just depends? 11:48

A. It just depends.

133 Q. Okay. And in your experience just, having bank or agency staff working with you, did that create any particular challenges in terms of your daily work at the centre? 11:48

A. Not significantly. Obviously you briefed them and gave them as much information that they would need to know

regarding the patient. However, the nature of their job is they are coming from the ward so they would have got quite a lot of information, I assume, from the ward before coming to day care. Their role in day care was to support the individual usually on a one to one and come to day care for those short number of hours and then go back to the ward for the remaining end of their shift.

134 Q. Okay. In terms of oversight, one of the things you've said is that you were uneasy about the lack of oversight you felt in MAH and that nobody really knew what went on in there. Just in terms of that comment, are you referring when you make that comment to your time in Moyola in terms of that Muckamore experience between 2008 and '10 or does that also include your more recent time in Cranfield? 11:48 11:49 11:49

A. It would be my experience when I originally worked in Moyola, whenever I was asked to give a statement, which I have done recently, I made a pass remarkable comment along the lines of even in my current workplace in the last week I have had a visit from an unannounced RQIA inspection. I have also in the same week had an internal monitor unannounced visit our centre and also a senior management call unannounced, and that's in a one week period. There are three different parties unannounced checking, in other words, how we are getting on and that's a complete contrast to my time in Muckamore. 11:49 11:50

135 Q. And in terms of that time in Muckamore, you've said in

your statement that you don't recall or certainly remember any instances of external bodies like the RQIA coming in or the Board members in terms the Trust who weren't working there normally coming in and inspecting or overviewing what was happening. Did you though, for example, ever see members of the Board or senior management within the Trust or within I suppose Muckamore, not just Moyola, doing inspections or walk abouts or spot checks or any sort of oversight? 11:50

A. Not in a formal manner. There may be senior day care management would call in and say hello very briefly. But it was very informal and they were usually going to see the senior day care workers for a meeting, but it wasn't a check up or asking questions as such. 11:51

136 Q. Okay. In terms of complaints and concerns and how those were dealt with or raised, you've said that reporting incidents involving patients and staff wasn't welcomed by your line manager and that when you did complete incident reports that it was made clear to you really not to do so and then because you were discouraged from doing so you then stopped essentially or didn't do it as often, didn't fill out reports as often. Why do you think that was the case? 11:51

A. I have no idea. It left a strong impression on me, that experience, it's very vivid in my head. I am being basically frowned upon for repeatedly going back to management and filling out accident or incident report forms. So after that, the amount of forms I filled out reduced significantly. 11:52

137 Q. And when you, for example, raised a complaint or filled out a form and you had an interaction with your manager, did you ever push back in terms of their approach?

A. I didn't know how to, how to take it further. It was just a case of, you know, you have to do what you're told to do. And I think when we are chatting with colleagues it does go along the lines of, you know, that's just the way things are, you know, that's just the culture. 11:52 11:53

138 Q. And in terms of, I suppose, a formal staff complaints procedure, at that time what was your awareness of that?

A. I didn't know that there was such a one.

139 Q. And you've said that in your experience you felt that staff were just expected to tolerate injurious behaviour from patients and not complain and you've said that, although you were discouraged from reporting, that you did still report some instances. So you've said in particular that you reported the two incidents that we've talked about in relation to the high risk patients with being locked in a room and then being punched. When you reported those to your manager, what was the response that you got? 11:53 11:53

A. It was just a cursory, she smirked and kind of laughed and 'thanks for letting me know, Phillip'. 11:53

140 Q. In terms of, I suppose, incidents with patients, were you ever injured in the course of those?

A. I've been injured a number of times, yes.

141 Q. And in terms then of what was done at the time, was there an immediate sort of response, were you given a break, were you first aided or --

A. No, the thinking on my part was it's important to record the information and pass it on to management. After that I didn't have any thought of, okay, this is the support I would like to get at all or this is the response, it was just recorded when and if I deemed necessary. 11:54

142 Q. You've referred to other staff and sort of overhearing staff or talking to staff about whether or not to report complaints or incidents and then sort of staff coming to the view that there was no point. When you say, I suppose, or when you talk about other staff experience, do you mean staff specifically under your line manager or are you talking generally in terms of Moyola? 11:55 11:55

A. Generally throughout the whole Moyola we would see each other during lunch breaks, you know, or some people might go out for a smoke but it would be just talking to each other. If you talked about the support from management it was that's just how it is, that's the nature of our job. 11:55

143 Q. In terms of reporting things directly to your line management, did you ever report or I suppose go over their head in a sense and report things to the overall Moyola manager or to other senior staff? 11:55

A. No, no, I did not.

144 Q. Can you help us with why?

A. It goes to the feeling of, I just felt quite uneasy with the amount of people who were related to each other in the work setting and it did make me feel quite uncomfortable to push against that, if I were to upset people.

145 Q. And I'm going to come to that in a minute, just before I do I wanted to ask you, do you know if there were any, I suppose, complaint mechanisms for patients? So if patients ever brought complaints to you were you able to point them in the direction as to how to make a complaint or were you ever in receipt of complaints that you had to deal with on behalf of patients? 11:56

A. If there is any types of complaints, as such, it would be quite informal in nature how it is dealt with and that would be expressed both verbally and in a written form to, on a handover if it was in written form it would be on my note, daily notes or recorded reports which the medical team on the wards would see sight of. 11:57

146 Q. Okay. I now want to turn to what you've described as the culture in Muckamore. And there's one occasion that you've described where, or sets of occasions, where staff would be gossiping I suppose with other staff about patients, about information about patients and those staff were related. So in terms of that general gossip on the wards, did you think that that was normal behaviour between staff or is that something that you thought was very unprofessional or inappropriate? 11:57

A. I found it quite unprofessional. I had no experience

of what is right and what is wrong, so to me it was just normalised to a certain degree. And it was very, very common amongst many staff to talk about patients, talk about incidents, including in front of other staff and including in front of other patients, it made little to no difference.

147 Q. And whenever you say that was common, the context that you've provided us to that was staff who were related to each other, now without mentioning any names, is that the sort of thing that you saw happen just between staff who were related, or is that something that you would have seen happen commonly with other staff who weren't related as well? 11:58

A. It would happen in both, related and unrelated.

148 Q. Okay. You referred to an incident involving an agency worker who you were told was bullied and couldn't work on a ward after she had reported a nurse's behaviour in relation to a patient. That I suppose really, and what you've said about complaints, really seems to suggest a closed culture where complaints weren't welcomed, I think that's really what you've described. And part of that you've referred to is in relation to close family connections within Muckamore. Was there anyone else or were you ever able to speak to anyone else within the much bigger Muckamore structure about any of that in terms of very senior management? 11:59 11:59

A. There was no-one to talk to apart from my work colleague with regards to supporting each other and dealing with this colleague who we knew was a lovely

lady who worked with us, but there was no avenue to seek additional support.

149 Q. You said in your statement that you felt that what happens in Muckamore stays in Muckamore. Was that comment, in terms of what you meant by that, are you referring to family relationships within Muckamore or was it a management culture generally or where do you think that sort of culture came from? 12:00

A. I just felt that there was no external bodies or persons that interacted with what was happening in Muckamore to feel that, you know, guidance or supervision. So if something were to happen in Muckamore how do other people find out about it, that's just a feeling as such. 12:00

150 Q. And were you aware of any types of whistle-blowing policies, was that something you were ever told about during your time there? 12:00

A. No, definitely not, definitely not.

151 Q. I want to ask you, I have only got two more topics I want to ask you about. The final one relating to your time in Moyola is in relation to support. You have said that you found your experience there with very challenging behaviours of patients and, I suppose, the culture there to be very stressful and you didn't feel supported by senior staff. Now, you've said that the culture at Muckamore was to speak to a manager if you needed guidance or support, but that that support was conditional or based on, depended on what issue you raised. So when you say that the culture was to seek 12:01 12:01

guidance and support from managers, was that something that you had experience of or were told by your manager to come and seek support from them?

A. So, in essence, like, my role was to report something that I felt I needed to report to a manager because that's what you do. However, the response was barely nothing, if anything. It was more okay, it felt like a tick box exercise. But very rarely you would get guidance or further comment. Sometimes you did. 12:01

152 Q. So there were occasions when you did? 12:02

A. There was, yes.

153 Q. You said it was depending on issues, what sort of issues?

A. It would be, for instance if there was an untoward new behaviour I would pass it to the manager, they would then pass it to the ward and the ward would respond and the senior would then come back to me and advise me on that particular topic. That would be kind of quite common. 12:02

154 Q. Okay, and in terms of then, apart from actually reporting specific incidents and concerns, in terms of your experience as a staff member there, did you ever make your line manager or anybody else, in terms of senior staff, aware that you were struggling in terms of dealing with those behaviours and your experience there? 12:02

A. I would just say I'm finding it difficult but the common response from my management and my colleagues was this is just the nature of the job.

155 Q. And did you feel, in terms of staffing levels or in terms of your training did you, how did you -- did you feel that they prepared you or you were well enough equipped for dealing with challenging behaviours?

A. To be honest, I was naive. I did not know any different. This is just the way it is. I did not know any different. I can reflect back and make a lot of comments about it but not -- at the time this was all very new to me. 12:03

156 Q. The final question that I have for you is then, you returned 12 years later to Cranfield 2 and you were ward based this time. And you, I think it's fair to say you describe a much more positive experience, would that be fair? 12:03

A. Yes, I found that I could talk for hours and hours about my experience more recently, totally enriching, wonderful experience. I don't have anything to fear. As I've said, many people, whether on CCTV footage watching me or not, it doesn't make a difference, we are here to do a job and support the patients as best we can. But the culture, the atmosphere is so, so much better, yeah. 12:04

157 Q. In terms of that I suppose significant change that you've described, what would you say or what do you feel is the core reason that there has been that, the change that you experienced in approach to patients? 12:04

A. I just feel it's more professional. It's definitely more caring, more individualised and it doesn't have a bad atmosphere about it.

158 Q. I have no further questions for you but the Panel may.
A. Okay, okay. Thank you.
CHAIRPERSON: Professor Murphy first.

MR. WARD QUESTIONED BY PROFESSOR MURPHY: 12:05

159 Q. PROFESSOR MURPHY: It's been so helpful to hear all that about the day service. I think you are the first person we've heard from about it. I have just got a couple of questions. You said at one point that the 12:05 behaviour therapist would sometimes visit and that some of your clients had behaviour support plans?
A. Yes.
160 Q. Had you been trained in behavioural support at all or was it completely new to you? 12:05
A. No training at all.
161 Q. And so do you think staff in Moyola were able to stick to those support plans or were they rather things that stayed in the file and nobody, you know, everybody ignored them? 12:06
A. To be honest, I think the support plans, to me, didn't seem that difficult to understand and they would be verbally explained as well by the behavioural therapist for us to initiate those guidelines based on their actual written work. 12:06
162 Q. So you felt that people were able to implement them in the Moyola situation?
A. Yes.
163 Q. Did you ever find that people were very reluctant to go

back to the ward at the end of the Moyola day? Did anyone have meltdowns about the thought of going back, for example?

A. Now that you mention, there was the odd occasion when that happened. Whether they articulated it, most often they wouldn't be articulating but they would be reluctant to leave the room.

164 Q. And what happened in that situation?

A. We'd seek guidance from our senior and on occasion we'd seek guidance from the ward as well. 12:07

165 Q. But on the whole what happened was somebody would just come back and --

A. They eventually of their own willing returned to the ward with us or the ward staff would come and encourage them to return to the ward. 12:07

166 Q. Okay, thank you. One other question, did you have any training in safeguarding?

A. I can speculate, I must have, I assume so.

167 Q. But it didn't stick in your mind?

A. It doesn't stick in my mind but I would like to think, even at that stage, there would be standard training. Yeah, I would say yes. I could be wrong. 12:08

168 Q. One last question, you've told us quite a lot about the day care file that you constructed for the guys that were in your room? 12:08

A. Okay.

169 Q. Who else would have seen that day care file? Was it entirely something you and your colleague were constructing that didn't really go anywhere else?

A. That would be correct, it would stay in our group room. However, if the senior day care worker wished to see sight of it or my colleagues wished to see sight of it, they were allowed to.

170 Q. But, for example, if someone was being resettled nobody would come over to Moyola and say oh, can I just have a look at his file to see what kinds of things he was doing with you, how he liked it? 12:09

A. There was very rarely any resettlement involvement, very rarely. I don't recall any occasion at all that they sought sight of the file, no. 12:09

PROFESSOR MURPHY: Okay, thank you.

MR. WARD QUESTIONED BY THE CHAIRPERSON:

12:09

171 Q. CHAIRPERSON: Just two short topics from me. One is just to understand the structure of a day care worker's hierarchy, as it were?

A. Okay.

172 Q. You went in as a Band 5? 12:09

A. Correct.

173 Q. Would there have been a Band 6 day care worker above you?

A. There was a senior, what banding they were, I do not know. 12:09

174 Q. Right, but there was a management structure as it were, within day care work?

A. Correct.

175 Q. So when you came across issues or one of your number

came across issues that concerned you, why couldn't you feed it up through your own day care worker structure?

A. Our day care worker structure would be there was two senior day care workers and each of the day care workers were allocated one of the seniors to refer to. I was referred to one of the seniors and if there is any issues, that was my line manager as such that I would refer to. That was the only avenue that I knew of. 12:10

176 Q. But, for instance, one of the comments you made was what happens in Muckamore stays in Muckamore. Did you express concerns to your own line manager? 12:10

A. Regarding?

177 Q. Anything that you saw in MAH, for instance when you were assaulted and nothing seemed to happen, did you express -- 12:11

A. Each and every time, each and every time, yes, each and every time. However, there was not really a response as such. You know, there was obviously, you know, sorry to hear, Phillip, you got hurt, I'll let the ward know. But that was pretty much almost it. It was quite informal. 12:11

178 Q. And in terms of being sort of dissuaded from filling in a form?

A. Yes. 12:11

179 Q. Did that come from your own line management as well?

A. It did, yes, she seemed very frustrated, laughing at me and frustrated at I kept coming into her office filling out forms whenever I started working in Muckamore. It

left a mark on me.

180 Q. The last thing I wanted to ask you about is just about the activities that you were able to assist patients with in Moyola. You would be in one of the group rooms? 12:12

A. Correct.

181 Q. And this was 2008 to 2010, wasn't it?

A. Yes.

182 Q. The first period that you were there. So what sort of activities did you partake in that the patients seemed to enjoy? 12:12

A. It could be artwork, it could be academic work, it could be cookery. We would go on to the Cosy Corner for something to eat or a snack. It could be a bus outing, a walk around the grounds, watching some TV, having a quiz, telling stories. 12:12

183 Q. And that would happen through the day?

A. Through the day, through the week, yes, yes.

184 Q. And the patients presumably would seem to engage in that? 12:13

A. Oh, yes, yes very much so.

185 Q. And enjoy it?

A. Yes.

CHAIRPERSON: That's all I have. I just want to agree, if I may, with Professor Murphy, it has been very useful indeed to hear from you. You are, I think, the first person in that position of day care worker that we've heard from, so thank you very much indeed for coming to assist the Inquiry. 12:13

A. No problem.

CHAIRPERSON: Thank you. All right I think our next witness is at 2 o'clock.

MS. BERGIN: Yes, Ms. Kiley is dealing with that witness. 12:13

CHAIRPERSON: Thank you very much indeed. Okay, 2 o'clock.

THE HEARING ADJOURNED UNTIL 2.00 PM. 13:34

THE HEARING RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you very much.

MS. KILEY: Good afternoon, Chair and Panel. Chair this afternoon's witness is A3, and you can see that 13:57 the screens are up as one of our anonymity measures. The witness is not at the table yet because there is an application for a Restriction Order, Chair, so I propose to make that now for your consideration before bringing the witness in. 13:58

CHAIRPERSON: Sure.

MS. KILEY: I'd ask to protect the application itself that the usual order be made over the application.

CHAIRPERSON: Certainly, if for the purposes of the application the feed to Room B can please be cut and 13:58 the only people remaining in the room should be CPs, lawyers and those who have signed the confidentiality agreement.

RESTRICTED SESSION

OPEN SESSION

CHAIRPERSON: I can indicate publicly that there will be a Restriction Order in relation to one part of this statement and we will go into closed session when that happens. 14:00

WITNESS A3, SWORN, QUESTIONED BY MS. KILEY: 14:00

CHAIRPERSON: A3, can I welcome you to the Inquiry. We have met before on one occasion. What's going to happen is that Ms. Kiley, as you know, is going to take you through your statement and the first part of that is just that you can sit there and listen and read and follow along and confirm, if that's right, that the statement is accurate. You will then be asked questions about Ms. Kiley. You have been given anonymity, so can I just suggest you take your evidence slowly because there is only so much I can do, obviously, if you do decide to reveal your own name, I can't do very much about it. So, just bear that in mind, okay, Ms. Kiley. 14:01 14:01

186 Q. MS. KILEY: Thank you. Hello A3, we have met briefly before your evidence today and I've explained the procedure. So just to recap, as you know the first thing I have to do is to read the statement you have made to the Inquiry into the record and then I'll ask 14:01

you some questions about it. I can see there you have a copy of your statement in front of you; is that right?

A. That's right.

187 Q. You should also have a list of ciphers in front of you and you will hear whenever I read your statement that I am not saying a number of the names of staff members to whom you refer, but instead will refer to them by cipher. If you want to have that in front of you to follow along, that might assist. And during your own evidence if you do wish to refer to a staff member by name would you check the cipher list first before doing so and refer to them by their cipher instead? 14:02 14:02

A. Okay.

188 Q. Thank you. So your statement is dated the 2nd of November 2023 and I'll commence reading now. 14:02

"I, A3, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry.

I have no documents to attach to my statement. 14:02

Throughout my statement I may refer to a number of documents which I no longer have in my possession.

My connection with MAH is that I was the Adult Safeguarding Lead for the Learning Disability Programme, employed by the Belfast Health and Social Care Trust from September 2019 to October 2020. At that time my role focused on MAH due to an Improvement Notice that had been recently imposed by the RQIA. 14:02

The relevant time period that I can speak about is between September 2019 and October 2020.

I understand that the time period to which I can speak is outside the timeline for the Operation Turnstone criminal investigation but it is within the terms of reference of the Inquiry.

I am a qualified social worker and approved social worker. My professional qualifications are Diploma of Higher Education in Social Work, Bachelor Degree in Professional Development in Social Work, Post Graduate Diploma in Mental Health Social Work, Specialist Social Work Qualification as..." 14:03

14:03

And it says there "ASW" but you have alerted me to the fact that it should say "ASG"?

A. No, sorry, ASW is correct in that instance, it was for approved social worker.

189 Q. Than you. So that reference is: 14:04

"... is specialist social work qualification as ASW for the purpose of the Mental Health Northern Ireland Order 1986 and a Master's Degree in Applied Social Studies (Social Work Leadership). I am registered with the Northern Ireland Social Care Council NISCC. 14:04

I feel very anxious giving information in relation to senior ex colleagues.

During my time at MAH I was Band 8A. I was employed by the Learning Disability Programme of the Belfast Trust. The context of this role was that it was a new post created following following the outcome of an 14:04
inspection by the RQIA. I do not have a copy of this inspection report. The RQIA had continuing concerns about MAH and had made a number of recommendations on foot of this inspection report. The purpose of this post and my role was to address some of these concerns. 14:04
My recruitment was a normal, open process of application, short listing and interviewing. The role required a social worker background and a minimum level of experience. Suitably qualified social workers from any health and social care trust could apply. I did 14:05
not have any family or friends working at MAH.

I did not have an induction when I commenced by role at MAH. I believe this may have been because this was a new role and because, as a Belfast Trust employee, I 14:05
was already familiar to some degree with MAH and MAH safeguarding processes. I did meet with the divisional social worker, H425, who was a frequent source of advice for me. The type of advice I sought from her was around things like the detail to be captured on the 14:05
incident database or how she felt the procedures could be strengthened. I would seek her support when there was a complex case. H425 was the liaison with RQIA in relation to safeguarding.

My first impression of MAH when I took up this role was negative. I felt that I had a lot of work to do to bring staff on Board due to the impact of the RQIA inspection, the ongoing PSNI investigations and MAH staff suspensions. In fairness to the staff, this post been quickly created and there was little time for introductions. I had been in and out of MAH in my previous role and there was no structured introduction or induction. I am not sure why this was. I felt that there were limits to what I could achieve in relation to adult safeguarding in light of the various PSNI and MAH investigations. I am not sure whether there was buy-in from MAH staff. This is my overall general perception and examples of why I felt this include poor attendance by staff at meetings, and reluctance to speak to ASG staff by some staff. 14:06 14:06 14:06

On an individual level, there were a number of MAH staff who did try to engage. Others, I felt, were unnecessarily defensive. I think that communication may have been an issue. For example, I overheard some MAH staff talking, whose names I do not recall, about their impression that the safeguarding concerns were being overblown and that this was simply a case of CCTV detecting restraint techniques known as Management of Actual Or Potential Aggression, MAPA, being poorly implemented. Overall I felt a defensiveness from MAH staff when I began working there for these various 14:07 14:07

reasons.

The matters to which I can speak are about the support around managing adult safeguarding ASG incidents, not in relation to particular incidents as such, although I may refer to certain incidents by way of examples. 14:07

I would not often have been on the wards at MAH but I was responsible for implementing procedures around governance and bringing staff on Board with those procedures. I dealt with how safeguarding incidents were reported and investigated. H425, the divisional social worker, who was the head social worker over all of the learning disability services had devised a new set of procedures for dealing with the safeguarding processes within MAH. These new processes had been communicated to MAH staff prior to me starting at MAH. These procedures were specifically to address the points raised in the RQIA Improvement Notice. My role was to I implement all of the new processes and procedures. I did not retain a copy of the Improvement Notice after leaving MAH but I recall that the RQIA required improvement in the recognition and reporting of ASG incidents and the protection planning at ward level. I was involved in the implementation of ASG..." 14:08 14:08 14:08 14:08

On that occasion, it should be ASG so I will correct that and re-read the sentence.

"I was involved in the implementation of ASG improvements required by the RQIA Improvement Notice.

I would have been on the wards in MAH occasionally, but that would not have been a regular occurrence. The referral process was such that any safeguarding incident was reported by any member of MAH staff on an electronic computer system, known as PARIS, to the safeguarding team on a form known as an ASP1. These ASP1 forms would have come to us as new referrals when we logged on to the PARIS system. Visitors or family could also make referrals by contacting any member of the safeguarding staff or hospital staff. 14:09 14:09

I felt that the atmosphere, approach and application of safeguarding depended on the ward manager/nurse in charge. There were a range of approaches to safeguarding at ward level. For example, some of the wards, i.e. Erne, were particularly anxious about safeguarding and would have reported every small concern, including things which were not safeguarding. Other wards had a better understanding of the process or more confidence in decision making. An example of this would have been Cranfield ward. I think in that case this was due to the ward manager, H67, communicating appropriately and effectively with me and my team. 14:09 14:10

My concern was when wards did not communicate, for

example, Ardmore ward. In Ardmore's case the staff on that ward would have made referrals but it was harder for us to see the intervention following the referral and to appreciate whether our recommendations had been acted on. It was hard for me to see whether the interventions or other recommendations I and my team had made as there were poor communication follow up from some wards. I could not gauge the effectiveness of our team's recommendations due to the lack of responsiveness of some wards. 14:10

The safeguarding team consisted of me as the safeguarding lead, and one social worker Designated Adult Protection Officer, a DAPO. The DAPO and I would pick up the incidents which were referred via ASP1 forms or verbally by family or visitors and the DAPO was responsible for investigating, which included watching any CCTV, speaking to the patient if possible, speaking to the family, speaking to the staff, and reporting any incident to the PSNI when the relevant criteria were met. We had access to the CCTV room by requesting a key from the manager's personal assistant. It also involved devising a protection plan in consultation with any relevant staff such as ward staff and day care staff. 14:11

A social worker attached to the ward would support the ward to implement the protection plan. Forensic patients, being patients with learning disabilities who

are undergoing or have previously undergone legal or court proceedings, were treated in the same way as other patients on the other wards. However, forensic patients' history, behaviour, interactions with staff and other patients would have had to be considered as part of protection plans. This posed challenges sometimes as forensic patients were held on Six Mile ward and there was limited scope to move them.

All of these tasks would not normally have been within my role as safeguarding lead. They would have been carried out by the DAPO and a social worker as investigating officer. However, there was so much being reported that I had to support the tasks normally carried out by the social worker, investigating officer and DAPO. There were a number of ASG referrals. These would be recorded in various locations within MAH. I do not have access to ASG referrals during my time at MAH, but believe this data will be held by the Belfast Trust..." 14:12

Presumably that should be, is that right?

A. I assume so.

190 Q. "The DAPOs and I tried very hard but we were overwhelmed with paperwork, processes and demands. Certain staff were trying to work with us, however, many staff were dismissive and did not see the value of what we were doing. I will go into each of these aspects in more detail below. 14:13

I did witness some good patient-centered care in MAH and positive working relationships between staff and patients. An example of this was when I visited the day care centre or saw arts and crafts or beauty sessions taking place in Ardmore. However, I also high levels of boredom and frustration among patients, staff standing around talking rather than being actively involved with patients, and a lack of imagination in providing stimulating suitable activities. Poor interactions between some MAH staff and patients, together with a lack of activities for patients would have appeared to have led to an increased number of ASG incidents. Difficulties with staff numbers had an impact. There was a high number of incidents of patients being aggressive to each other and also allegations against MAH staff. There were a high number of referrals to ASG for the reasons set out below. 14:13 14:13 14:13

The threshold and process for reporting safeguarding concerns at MAH was changed. The regional policy provides two definitions to be applied in ASG concerns, "adult at risk of harm" and "adult at risk of harm and in need of protection". All the patients, by virtue of their learning disability and their in-patient status, automatically fell into the first definition. The second definition is met when there is a concern that another person is causing deliberate harm and intervention is needed to protect that patient. The 14:14 14:14

process laid down by the policy allows for appointed persons, ward managers or a nurse in charge in this instance, to manage lower level referrals, that is where no need for protection from deliberate harm is identified by way of an alternative safeguarding response. 14:14

Where a protective response was required, the referral is sent to a DAPO to respond and investigate. A decision was taken, I'm not sure by whom, that all safeguarding concerns within MAH should go to DAPOs. This was understandable in the context of serious concerns at the time but it created many problems. The workload was immense. Patient and families' anxieties was heightened as everything was deemed adult in need of protection and MAH staff anxieties were increased. 14:15 14:15

There was a lot of anxiety and confusion within MAH amongst staff as to what should or should not be referred as a safeguarding incident. To attempt to deal with this the DAPOs and I took a number of steps, including providing support sessions in person or via Zoom to help staff with completion of ASP1s. There were also opportunities at the many meetings described later in this statement to seek advice and clarification. We also operated an open door policy and were very happy for any staff member to visit us for advice guidance. 14:15 14:15

The new procedures dictated that every small incident that could possibly be interpreted as safeguarding should be reported and that every referral be accepted as a potential safeguarding incident. I will try to explain this in more detail. Imagine a patient bumps into a chair as they walk past it, maybe hurts their toe, that is not appropriate for a safeguarding referral. The ward manager could deal with that using other processes. But the anxiety and lack of understanding was so high that it would be referred to us in some instances, so we would check it out, maybe even view CCTV and complete a lot of paperwork. It took a lot of time to conclude that this was an inappropriate referral. Meanwhile everyone is highly anxious and the atmosphere is tense. 14:16

The "at risk of harm" category allows for staff to manage the incident to explore what happened and implement their own plan to try and prevent this harm." 14:17

I'm going to pause there, A3, because you have already alerted me to the fact that you have a minor modification to that sentence?

A. It should say "the ward manager or other senior staff", it wouldn't just be any member of staff on the ward. 14:17

191 Q. So that reference to staff in the first line should be "ward manager or senior staff"?

A. That's correct.

192 Q. I will read that in with that correction.

"The "at risk of harm" category allows for the ward manager or senior staff to manage the incident to explore what happened and implement their own plan to try and prevent this harm. Staff can always seek the advice of a DAPO if they are not sure. Sometimes it is appropriate to refer this type of concern to ASG, depending on the context of the situation. The new processes in MAH removed this layer and these incidents would all be referred to ASG. In the context of MAH this is perhaps understandable but it created a lot of anxiety for patients, families and staff and a lot of work for just two safeguarding staff. 14:17 14:17

The second definition, "adult at risk of harm and in need of protection" must always be referred to safeguarding. This would then be investigated, referred to the PSNI where criteria was met and a protection plan implemented. The safeguarding team audited the protection plans on patient records to ensure that these protection plans were appropriate and available to MAH staff at each ward handover and throughout their shift. We conducted these audits on a monthly basis. 14:18 14:18

We were so busy because we were dealing with all these types of incidents and also historical ones. Old incidents regarding discharged patients were coming back as inquiries were raised and these incidents had

to be reopened. Former patients or family members were contacting MAH to report incidents. Even if the incident had been investigated previously, we would look at it again, which is correct as patients and families needed that reassurance, but there was too much for two people to do. We could only go on the available notes so we generally were not able to provide any new information. A third person was added to the team, H251, who was a social worker DAPO. 14:18 14:19

There was a huge volume of work for only two to three people in the team. MAH had around 50 patients at that stage. In the normal course of things, working to the regional policy, one DAPO should have been enough with social workers completing the investigating officer role, but MAH was a very different environment. In comparison, in the community teams the four team leaders were also DAPOs and were responsible for approximately 1,500 clients including any safeguarding referrals. 14:19 14:19

The safeguarding team was swamped with very paperwork heavy process driven tasks. It involved endless reporting and recording and we had little resource do that. We had no issue accepting referrals and trying to support staff to implement protection plans and safeguard patients, but we did not have the resources, the staff buy-in or the management support to be successful. We had no administrative support although 14:20

the social work team administrative assistant helped out.

The DAPO and I were based in MAH at the time. The atmosphere generally in MAH was not very welcoming or supportive with the exception of a few individuals. I do not wish to disclose their names. 14:20

I was managed by senior staff in the community, Belfast Trust, not by MAH senior staff so I did not fall into the normal structure in terms of support for staff and management. My line manager at Belfast Trust while I was at MAH was H406. 14:20

The DAPO has responsibility for making decisions about whether a safeguarding referral is appropriate and how it should be investigated. A DAPO's job, with the support of investigating officer, social worker, is to advise, co-ordinate an investigation, implement a protection plan and decide if referral to the PSNI is necessary. Where a criminal offence is known or suspected, the DAPO will contact the PSNI to discuss the matter with the PSNI officer, Public Protection Unit, and agree if the incident should be investigated as a single agency, PSNI or Social Services or joint protocol, PSNI and Social Services. 14:20 14:21 14:21

It would be my band, Band 8A Safeguarding Lead or the Band 7 DAPO's job to make these safeguarding decisions.

On several occasions senior management of MAH made it clear that they disagreed with our decisions and were unhappy with our approach. I feel very uneasy providing the names of these individuals. This did not stop me from doing my job as I did what I knew was right and in line with policy but I felt unsupported as I knew that senior management often disagreed. 14:21

The DAPOs and I still did our jobs and referred incidents to the PSNI even with the understanding that I was upsetting someone more senior. I felt it was better to have the PSNI advise a referral was not appropriate rather than risk not referring something that should have been with the PSNI. 14:22

There were two different management streams. The safeguarding team and I were community staff managed by the community side of the programme and everyone else at MAH was hospital staff, managed by the hospital side of the programme. In a sense that made it easier for me to go against the senior management of MAH as I answered to my own senior manager. However, it also made it more difficult because I was not really made to feel welcome at MAH and I felt that I was doing something wrong in someone's else's house. 14:22 14:22

The MAH manager at the time was H300 and the manager above him was H627. No-one went out of their way to say to me, 'no don't do that', however, I felt that I

was viewed with suspicion and was seen as making waves as MAH. There was a very protective feeling around the nursing staff from various members of the senior management team. I understand the anxieties around the ASG investigation, but felt that the defensiveness and resistance I encountered was unnecessary and unhelpful. 14:23

There were some more receptive staff members at MAH but I felt that the ASG team were always having to excuse ourselves or explain ourselves to try to find a way in. 14:23
Initially incident numbers dropped a little and I felt we were making some progress, but the incident described earlier at paragraph 28 and the attitudes around it changed my mind.

14:23

The fact that I left after a year demonstrates that I did not feel like the new procedures were working or that I would be able to be successful in my role. I had no confidence that attitudes and culture in MAH embraced ASG. 14:24

MAPA is a taught system of safely restraining someone and moving them if they were behaving aggressively towards someone else or hurting themselves. Some staff in MAH were overheard saying they believed the PSNI 14:24
investigation was about poorly executed MAPA and believed that the safeguarding team were creating problems. We were not in a position to correct them on that. The safeguarding team actually knew very little

about the PSNI investigation. Even as Safeguarding Lead, I knew very little about it.

Trying do the job was completely overwhelming and I did not feel professionally safe. I felt that I needed to move as the job was completely unmanageable and I was not supported. The new procedures did have a certain degree of success but were not sustainable and outside of the regional policy. We raised awareness of safeguarding and improved understanding within MAH to a small degree. I did not feel like I was ever going to achieve enough as there seemed to be an unwillingness to really do what needed to be done. There will always be safeguarding incidents but they should not be tolerated, no matter how minor. For example, if we recommended that two patients be separated because they repeatedly hit or threatened each other, we would be told that this was not possible due to limited space and that was that, leaving them at risk of hurting each other again. 14:24 14:25 14:25 14:25

Senior management regularly disagreed with me. I should not have had to explain to senior staff why referrals were being made and why I had spoken to the PSNI. This was my decision and within my job role. I did not understand how, with what I believe was something like 70 suspended members of staff and all referrals regarding staff going to senior management, comments dismissing ASG concerns could come back from 14:25

senior management.

There were several opportunities every week or month to review and discuss ASG incidents. These opportunities are described below. 14:26

On every ward there was a daily safety brief covering all types of safety issues. The ward social worker, not the DAPO or I, although we could attend if we chose to and we did go to some of these briefings, would 14:26 attend and ensure safeguarding was included. That is 25 meetings, five wards times five safety briefings, that a social worker could be attending each week.

While I was not employed by MAH directly I would have 14:26 had the same level of access to patient information as MAH staff.

There was a live governance meeting each week looking at all governance issues including safeguarding. This 14:26 was chaired by the Clinical Director and was attended by all ward or day care managers, Psychology, medical staff, an allied health professional manager and ancillary manager, at least one social worker and someone from safeguarding. 14:27

Each ward also had a specific safeguarding meeting each week which the DAPO chaired. All staff were invited, including medical staff, Psychology, and day care staff

in an effort to ensure everyone contributed to safety planning. We would look at all referrals and go through the protection plans. We checked if the plans were working and whether any amendments were required to be made. We asked if further information was required or any updates required to the plans. There were five meetings per week, one per ward. 14:27

Every month we had a safeguarding forum, usually chaired by the divisional social worker or myself, where a representative from every department of MAH was invited, including nursing, Psychology, medical, allied health professionals, catering and cleaning staff. This was very poorly attended. There would have been over 20 staff invited to attend. On average from memory, only around six staff attended these meetings. 14:27 14:28

There was an Assistant Service Managers (ASM) meeting every month where ASMs, three senior nurses, and a DAPO would discuss each ward and review any actions needed to improve safeguarding. 14:28

We also attended the monthly ward manager's meeting that the divisional nurse chaired. Either the DAPO or I attended part of that meeting to raise the profile of safeguarding. We tried to make the message positive if possible, pick up on any good practice, but we also said whatever was needed providing critical feedback if required. 14:28

On one hand it felt like we were shouting safeguarding from the rooftops with all these meetings, but on the other hand I felt like we were not being heard and not making any progress. I appreciate there were huge challenges and staff shortages, however I felt our advice fell on deaf ears. 14:28

I initially used a vacant office but when that post was filled I was left with no office, despite being in a crucial senior role. I either worked from a laptop on my knee in the DAPO office or sometimes I went to one of the Belfast Community offices which were located in the Everton Complex, Crumlin Road. I felt it was important to be on site though so I was in MAH as much as possible. I asked senior management to find me an office but this never happened. There was no administrative support to assist with the large volume of paperwork we were required to complete. The social work team administration assistant helped as much as she could but this was not her role. 14:29 14:29

We started to track safeguarding referrals in a complicated data sheet which detailed the date, the time of day, the area the incident occurred, the ward and what else was going on at the time. The purpose was to try to see patterns and trends and look at what was happening. This data sheet was maintained and stored electronically by the social work department 14:29

administrative assistant. I cannot recall the exact name of the folder however it was likely named "ASG safeguarding referrals" or something similar. The DAPOs and I had access to the data sheet and we shared the information from it at the monthly safeguarding meetings.

The data sheet did highlight some patterns. It demonstrated had a high number of patients hitting other patients at meal times. We tried to address this and asked catering if they could do two sittings but we were told that for health and safety reasons this was not possible. We tried to see if we could send some patients to the cafe, for example to address some of the trigger points. When we drew a blank or our ideas or suggestions were not possible, it all just seemed to stall, nothing changed. Some staff did simple things like spreading out all of the tables. They had an awareness and were trying. Other staff faces went blank and you could see their eyes roll when one of us walked onto the ward.

I recall H67, as I have mentioned above, who really tried hard. He came to H283 and me several times to ask what more he could do. He made the effort and understood the need. I would not go as far as to say that others were obstructive but they just were not as on board with what was required.

At times we would walk onto the wards and the staff would be standing around the nurses station. We frequently saw this on CCTV too and they all moved as soon as they saw us.

14:31

H301, whose job title I believe was co-director, was in post when I started. I felt she was very supportive, and approachable. I was confident she would make a big difference but she moved to a new post and H627 then came into her post. H627 was not supportive at all. 14:32
H300 found supporting ASG difficult. This may have been for many reasons. We sat in different management structures and he was trying to improve morale in the hospital. My impression was that ASG was seen as creating further tension. 14:32

I was left feeling unsafe to the point that I had to leave. My feeling unsafe came from a number of factors, including understanding that the senior management disagreed with ASG decisions and seeing that 14:32
I was not viewed as part of the senior team in MAH as evidenced by office space not being made available and poor attendance at meetings. I think I would still be in the role if I felt safe and supported.

14:32

I thought in taking up the post I would implement processes and make a difference. I quickly realised there was too much going against me. The processes were far too laborious and complex and the atmosphere

was not receptive.

H283 and I viewed any incident that was complex or we needed to know more about on CCTV. We watched all incidents where a staff member was the alleged perpetrator..." 14:33

CHAIRPERSON: Do you need to pause?

A. I'm just pointing something out that's --

CHAIRPERSON: If we just take it off the screen for the moment just in case there is something. Have we missed a cipher or are we all right? 14:33

193 Q. MS. KILEY: No, we're okay. There is a name in the next paragraph which I am not going to say, but it's not ciphered, it's a first name only but I don't intend to say it. Thank you. 14:34

"H283 and I viewed any incident that was complex or we needed to know more about on CCTV. We watched all incidents where a staff member was the alleged perpetrator. Sometimes this cleared the issue up easily or led to a PSNI referral. We had to rely on the ASMs to identify the staff for us. I do not know the name of the person..." 14:34

And you say what you think the name might possibly be.

"...who operated the CCTV. At the beginning we had to make an appointment with him to watch the CCTV which

could take a week or more to organise. I did not feel that this was right and I had to insist on us being trained ourselves so we could view the CCTV on the same day something was reported. This was supported by H425. 14:34

Contemporaneous CCTV viewers who were former Belfast Trust staff and who I believe were employed by the Belfast Trust on a sessional basis came in and took part in a programme to watch a random selection of CCTV. I believe there were around six individuals, mostly retired social workers who were employed. I do not recall their names. They checked if anything was missed that should have been reported, this did pick up some incidents which were reported such as the one described above. 14:35 14:35

I did deal with concerns and complaints from families. These concerns and complaints would come to me via telephone and/or meetings requested by families. I do not recall ever seeing any formal written complaint about safeguarding. Complaints we dealt with were informal and managed by phone call or meeting with the family. We also met the MDT and with families who had made more general complaints to the hospital management to provide an ASG perspective. 14:35 14:35

In relation to the reporting of risks with staff to external bodies this would have mainly lay with other

members of the senior management team. I knew that I could raise issues with NISCC in relation to MAH social care staff but I do not recall having to do this during my time at MAH. Decisions about staff suspension or disciplinary action were not within my remit. 14:36

In relation to corporate nursing support, I recall that the divisional nurse, H315, was approachable when I had questions about nursing practice and perhaps if I needed some support about making some changes happen. 14:36 She was helpful to me.

In relation to line management at MAH my manager, H406, was not a member of MAH staff and was based in Belfast Trust. She would have been on site in MAH on occasion 14:36 and may have visited me. H425 would have been my supervisor within MAH. H425 was not based in MAH but was very frequently there.

There were lots of layers trying to identify 14:36 safeguarding incidents but this left us drowning in a sea of work which could not possibly be processed. I felt like we never made headway as there was so much of it and our efforts were not well received.

14:37

I have worked in various adult safeguarding roles since 2017. I enjoyed the role and wanted to improve systems. I accepted the MAH role as I hoped I could improve the safeguarding responses there. I strongly

believe that adult safeguarding should be treated as a core concern in all health and social care settings with extensive levels of training, resources and governance. I did not see safeguarding taken as seriously as it should have been by all the staff while I was at MAH. Safeguarding is a whole system issue. It should be considered as part of recruitment, training, governance, every aspect of every service for patients and service users. No patient or service user should experience harm or abuse and no family member should have to worry that this might happen to their loved one. The culture of all services should actively promote ASG as everyone's responsibility with everyone understanding and playing their part and fully embracing it. It is not something that belongs to just one team or social workers. 14:37 14:37 14:38

At MAH safeguarding felt like an afterthought and I saw that MAH staff did not feel that safeguarding was part of their role. I believe this is fundamentally wrong, safeguarding is everyone's responsibility." 14:38

And then if you turn over the page you give some detail about giving evidence and you sign the declaration of truth and that is dated the 2nd of November 2023. So, A3, having heard me read that out and, subject to the corrections you've already identified, are you content to adopt that statement as your evidence before the Inquiry? 14:38

A. I am.

194 Q. The good news, A3, is because you have adopted it I am not going to ask you to go through every single matter that you have raised in your statement again, but there are some issues that I want to pick out and deal with. 14:39
And the first thing I wanted to ask you about is the nature of your role. You have told the Inquiry that the title of your role was Adult Safeguarding Lead for the Learning Disability Programme and you commenced that role in September 2019 and you have also described 14:39
how you are a social worker by background.
Did you ever receive any specific training in respect of working with learning disability patients?

A. Social work training is generic in nature, it doesn't tend to focus in on any particular area of social work 14:39
so a qualified social worker can move to work in any area. I have -- so I don't have specific training in learning disability but I have a lot of experience in working with learning disability. When I came into post in Belfast Trust in 2016, there was a specific 14:40
learning disability induction that senior staff in various disciplines provided information and I suppose a training of some sort around things like autism, managing challenging behaviours, MAPA, we all do specific MAPA trainings at various levels depending on 14:40
the role. Then my approved social work training is relevant as well because it is very specifically about mental health which is a common comorbidity with learning disabled adults.

195 Q. You referred to some training you received whenever you came into the Trust in 2016, what role were you appointed to --

A. I was a social worker with the community teams. That standard learning disability induction was made available to everybody coming into the learning disability programme. 14:40

196 Q. Okay, so you got that whenever you came into the community team in 2016?

A. That's right. 14:41

197 Q. But you didn't get any further specific learning disability training whenever you moved to Muckamore in 2019; is that right?

A. That's right. I also had completed the specific safeguarding training after 2016 but there was nothing specific when I went to Muckamore. 14:41

198 Q. Okay. You explain in your statement that you weren't employed by Muckamore directly, you were employed by the Belfast Trust and you go on to tell the Inquiry that your manager, your line manager, H406, was an employee of the Belfast Trust but not based at Muckamore; is that right? 14:41

A. That's right.

199 Q. Is it right then that the staff that you were working with at Muckamore in your new role had a different management structure to you? 14:41

A. That's right. Although Muckamore is part of Belfast Trust so we are all ultimately employed by Belfast Trust and Muckamore was part of the wider learning

disability programme of care, although we sat within separate management structures.

200 Q. Yes, I just want to understand a little bit more about how that worked because, as you describe, there are separate management structures but Muckamore is itself part of the Belfast Trust? 14:42

A. That's right.

201 Q. So where do those separate management structures meet?

A. I suppose they would have met at a higher level than I was working at, they would have met probably at co-director level whenever the various senior staff below that level were meeting and providing assurances to that person. It's an interesting question because when I was in Muckamore I never really felt that I was in Belfast Trust as such or that I was in the learning disability programme. Maybe it was to do with the geographical nature but it just felt different as well. 14:42 14:42

202 Q. And I think you say elsewhere in your statement that as a result of that management structure and the differences in management structure it was perhaps easier for you to go against senior management, the senior management of Muckamore's decisions? 14:43

A. That's right. I think it worked in both ways. I think it made it easier for me to make the decision that I knew the senior Muckamore managers would not be happy with because I knew my managers were supporting me with it, but it also made it more difficult because the managers in Muckamore weren't necessarily able to see it from my point of view. So it felt like I was always 14:43

in the middle and trying to negotiate my way through.

203 Q. But you did you have a supervisor at Muckamore; is that right?

A. That's right.

204 Q. H425? 14:43

A. That's right.

205 Q. So if you encountered a concern who was your first port of call, was it your line manager or your supervisor?

A. It probably would have been my supervisor because she was more au fait with the safeguarding processes in 14:44 Muckamore and with the issues then, although she also wasn't based in the hospital she was there very often.

206 Q. Okay. And you did just refer to your earlier role in the community team which you took up in 2016. In your statement you do refer to having been in and out of 14:44 Muckamore in your earlier role. Is that the role you are referring to that took you in and out of Muckamore, the community team?

A. That's right, as a social worker in the community team I would have went up to discharge planning meetings in 14:44 the hospital. I then became team leader and wasn't doing so much of that but would have went occasionally and then obviously when I got the safeguarding lead post I was there all the time.

207 Q. In that earlier role how often would you have been in 14:44 and out of Muckamore?

A. I was only a social worker in the team for about six or seven months before I became team leader, so I would say probably maybe once or twice a month.

208 Q. And were there particular awards that you would have visited on those occasions?

A. I think I was on, now my memory is going to go, I am going to forget one of the names, I think I was on Ardmore and the one next door was Donegore. I think on those more than the others. The Cranfields were admission wards so maybe not as frequently and the other ward was a longer stay ward so probably Ardmore and Donegore. 14:45

209 Q. Okay. Just to be clear, the matters that you describe in particular in your statement arise from the period of time whenever you were in the adult safeguarding lead role? 14:45

A. That's right, that's right.

210 Q. Is the Panel then to take it that on those earlier occasions whenever you were in and out of Muckamore, you didn't see anything that gave you cause for concern? 14:45

A. I didn't see anything that caused me concern then. I wouldn't have had, I wouldn't have had like huge amounts of access. I would have waited in the hallway of the ward I was visiting, been taken into the conference room that was meeting was in and been taken out again through doors and corridors that I had no access to without a member of the Muckamore staff taking me so I didn't see or hear anything that concerned me, but I equally had no opportunity to. 14:46 14:46

211 Q. When you took up the new role you described that it was a new post?

A. That's right.

212 Q. And that it was created arising from RQIA inspections and improvement notices. I think in particular at paragraph 11 you refer to that and you say that your role was to implement all of the new processes and procedures and those procedures arose from an RQIA Improvement Notice that you didn't retain. I am going to ask you to look at a document on screen. If we could bring up the additional documents, please, the Inquiry has received an Improvement Notice. You can see it's on the screen in front of you there, the reference is IN000005, dated 16th August 2019. And in fairness to you, you say that you didn't retain a copy of any Improvement Notice but I want you to look at this one with me. Can we make it smaller so we can see that whole page please? So you can see hopefully there on the screen the reference number and the date which I have given you. If you look down to the final box, that's entitled "failure to comply, 5.3 criteria, 5.3.1 ensuring safe practice and appropriate management of risk" and the criteria are identified there, the criteria that ought to be complied with. If we look over the page to page 2, please. It's quite small on the screen I think but as you can see that top paragraph it says there: 14:46 14:47 14:47 14:47 14:48

"The Belfast Health and Social Care Trust has failed to comply with the criteria above by failing to ensure effective safeguarding arrangements are implemented and

ensured in Muckamore Abbey Hospital."

And in the paragraph below there is reference to an unannounced inspection that was carried out by RQIA on the 26th to the 28th of February 2019. And the notice says: 14:48

"Our inspection team did not find evidence of effective deployment of safeguarding referrals, of the implementation of learning arising through safeguarding investigations, or that outcomes from safeguarding investigations were positively impacting patient well-being. A structural disconnect between professional staff was evident. In line with our enforcement procedures we invited the Trust to an intention to serve an Improvement Notice meeting on 7th March 2019." 14:48

The next paragraphs refer to what was discussed at that meeting. Then further down the page you can see reference to another unannounced inspection on the 15th to the 17th April 2019 and it said: 14:49

"Our inspection team evidenced limited progress in relation to safeguarding arrangements. We remain concerned about implementation of learning arising from safeguarding investigations. Evidence that the outcomes from safeguarding investigations were positively impacting patient well-being. We note that 14:49

the meaningful implementation of protection plans was a challenge."

there is reference again to a further intention to serve an Improvement Notice meeting. If you scroll over the page you will see there are improvements identified as necessary. Point one: 14:49

"To implement effective arrangements for adult safeguarding at Muckamore Abbey Hospital and to ensure that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding. This includes: 14:49

(a) requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations. 14:50

(b) that there is an effective system in place for assessing and managing adult safeguarding referrals which is multidisciplinary in nature and which enables staff to deliver care and learn collaboratively. 14:50

(c) that that protection plans are appropriate;

(d) that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care and that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding is improved. 14:50

2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding

across the hospital site. This should include ward sisters, hospital managers, Trust senior managers and/ or the executive team as appropriate.

3. To implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital." 14:51

Now is that the RQIA Improvement Notice which you have referred to at paragraph 11 as giving rise to new processes which it was your role to carry out? 14:51

A. I don't recall ever actually seeing the notice. I was told by my line manager or my supervisor at the time, H425, that my post was created in response to I would assume that that's the right one but I don't recall ever seeing it. 14:51

213 Q. Okay. And you referenced H425 there, you do say at paragraph 11 that H425 had devised a new set of procedures for dealing with the safeguard processes. They were devised before you took up your role in September 2019; is that right? 14:51

A. That's right.

214 Q. Can you describe to the Panel what those new processes were and particularly how they differed from what went on before?

A. I'm not sure how much I can comment on what went on before because I didn't work there before. But, the standard procedure would be that anybody, any member of staff who has a safeguarding concern would complete what was then an ASP1, which is the referral form, and 14:52

they manage it according to those two definitions that you read out earlier. Either it's the lower level and the ward manager can deal with it and implement an alternative response, or they send it into the DAPO and they make a further decision about how it should be managed and investigated. 14:52

What changed then when I came into post was that that layer of the ward manager making that decision stopped and it was felt that everything should go by a DAPO to provide that level of assurance. I notice that Improvement Notice also talks about trying to make sure staff were more aware. So, for example, when protection plans were implemented there was a system of folders that were begun to be kept on the ward, I think they maybe were blue folders from memory, where all the protection plans for each patient would have been kept in that blue folder so no member of staff had the opportunity to say I don't know what the protection plan is, because not every member of staff would have access to a computer during their shift, and some staff not at all. So the idea was that this blue folder was there, that they all knew they should read it and check protection plans and if anybody came into the ward and said what was the protection plan they would be easily able to find that out. We had all those various meetings that are described in my statement as well which gave so many opportunities to raise safeguarding concerns, to check if protection plans were effective 14:52 14:53 14:53

or not. We implemented the data sheet so that we could try to look for trends and patterns. The safeguarding staff and myself operated a very open door policy and really encouraged or tried to encourage all the staff to come and talk to us and tried to be very visible ourselves within the hospital. And my colleague offered support sessions to all the staff in the hospital to help them understand what a safeguarding concern might look like and how to complete the ASP1, because not all staff seemed to have the confidence to do that. So I think we put a lot of measures in place to try to improve that understanding and that confidence. 14:54 14:54

215 Q. DR. MAXWELL: Can I just clarify, when the policy changed from having these two categories of safeguarding concern, one that would be managed by senior staff on the ward, and one that would have to go to the DAPO, how was that decision made? 14:54

A. It was made before I came into post, so I can't honestly answer that, sorry. 14:54

216 Q. DR. MAXWELL: Do you know of any consultation there was about this?

A. I don't remember if any consultation happened. Whenever I first came into post I recall a meeting with all the ward managers and deputy ward managers, the divisional nurse and I think my supervisor was there as well at which we discussed these changes and we shared templates and forms that things were going to be recorded on. I'm not sure if that was the first they 14:55

had been made aware of it or if it happened before I came into post.

217 Q. DR. MAXWELL: Following on from that, the idea of taking the protection plan and putting it in a folder on the ward actually raises some questions for me because we encourage staff to look at the patient's care plan and if the safeguarding plan is somewhere else, that potentially offers an opportunity for it to be missed. So do you know if that was discussed with the ward staff or was that a decision made off the ward and imposed? 14:55

A. I don't know if it was discussed at the time of the changes, but it's something that I discussed later on with my supervisor and with another person, and I can't remember her name or her title but she had been a nurse and her role at that time was about, it was about governance and making sure all the electronic systems and the care plans and things were up-to-date. And we took the decision then that the protection plans would be uploaded on to that PARIS system as well which turned out to be an incredibly complicated process and took a long time to get it right, but we did eventually have them in both places then, in the PARIS system and on the folder on the ward. 14:56

218 Q. DR. MAXWELL: So how long were they in this folder away from the care record before they went on to PARIS? 14:56

A. From memory quite a few months because I left after a year and it wouldn't have been too long before I left that we were having those conversations about -- in

fact it would have been summer time, I started in September so probably the next June. I just have a memory of a meeting and it being a warm day. So probably several months before that gap was realised.

219 Q. DR. MAXWELL: Potentially nine months they were out of sync with the other patient records? 14:57

A. Possibly.

DR. MAXWELL: Thank you.

220 Q. MS. KILEY: Just following on from that, Dr. Maxwell had asked you about any discussions or consultations about the procedures before they came in. Whenever you took up your role, do you know if the staff who you were working with, the ward staff in Muckamore received training about the new processes? 14:57

A. I have no idea. I know that myself and my colleague primarily -- 14:57

CHAIRPERSON: Can we just pause for a second, is there an issue?

INQUIRY SECRETARY: I think there may be an issue with the sound so it might be best to get it sorted. 14:57

CHAIRPERSON: Is it not going through to Room B?

INQUIRY SECRETARY: It is in the remainder of the room, but the microphones seem to -- I'll just speak to the tech.

CHAIRPERSON: Sorry to interrupt you, we have got to make sure everyone can hear. I am going to ask, are there problems hearing in the room? There aren't. Could I ask you both to keep your voices up? We are getting a thumbs up from the back of the room so that 14:58

should be all right. Witness, if you could lean forward.

A. If I lean forward is that going to help?

CHAIRPERSON: I think that's going to help.

221 Q. MS. KILEY: Our microphones have been moved and we will try to keep our voices up. If there is any other issue the secretary will alert us. I asked you whether you were aware whether MAH staff had received training on the new processes? 14:59

A. I'm not sure if they have received training or not and I suppose that's part of the issue of this, two different sides of management going on, but certainly my colleague, H283, would have offered a lot of support to staff on recognising safeguarding concerns and in completing the ASP referral forms. It was Covid at the time so if she wasn't able to get onto the ward maybe if there had of been a Covid outbreak, she would have provided that on Zoom to try and make sure staff did have that, but I don't know if there was any other training. I should maybe clarify a point about that. So the regional policy provides the two definitions and it is the regional policy that states that the adult safeguarding Champion in this case would be the ward manager that can make that screening decision as to whether they manage it or whether it goes to a DAPO. So what was changed was that that screening decision was taken away from them and passed just to the DAPO. If you like it was less of a decision making process for them, so they probably needed some training, maybe 14:59 14:59 14:59 15:00

on completing the paperwork, but certainly not on the decision making because the decision was just taken out of their hands.

222 Q. What about you, did you receive any additional training given that you were going into a place that was adopting new processes different to the regional policy? 15:00

A. Other than speaking with my supervisor, no.

223 Q. You say in your statement you didn't receive an induction whenever you started? 15:00

A. That's right.

224 Q. Were you surprised at that?

A. In hindsight, yes, I'm surprised. At the time I don't think, I don't think it surprised me because it all felt like it was happening very quickly. The way the post came around in response to the Improvement Notice and it being advertised and interviewed so quickly, I suppose I didn't really have time to think about it. I was introduced to the new procedures and I just got on with trying to implement them. In hindsight now it seems strange and things may have been more successful. 15:01 15:01

225 Q. CHAIRPERSON: Could I just ask about that. Obviously you knew MAH anyway?

A. That's right.

226 Q. CHAIRPERSON: You knew Muckamore anyway so it wouldn't have been induction to the hospital? 15:01

A. No.

227 Q. CHAIRPERSON: It was an induction to the system?

A. To the system and perhaps more time to meet more staff

and get to know and be known maybe might have been useful.

CHAIRPERSON: Okay.

228 Q. MS. KILEY: You were familiar with Muckamore from your earlier post and in your earlier post you described how you weren't actually in the hospital wards too often. What about this new post, how often would you have been on the hospital wards? 15:02

A. The office that I used when I first came into post was based on the admin corridor of Cranfield, so although not on the Cranfield ward would I have seen staff and patients coming and going a lot there. The other wards I maybe went on to maybe once a week or once a fortnight, it would have been my safeguarding colleagues would have been on the wards more than I was. 15:02

229 Q. I want then to move to ask you about your actual experience in the role. You've heard me read out your statement and it seems to me, and you can tell me if this is fair, you have identified two real challenges in carrying out your role. One was the workload and the associated administrative burden of that process and the second was, if I can categorise it as staff attitude to safeguarding. Is that a fair identification of the main challenges in your role? 15:02 15:03

A. That's fair.

230 Q. If I take each of them in turn, the first thing I want to ask you about is workload. You particularly describe this at paragraph 15 of your statement, you

say there was a large number of ASG referrals. At paragraph 17 you describe the reasons for that. One of the reasons you say was that the threshold and processes for reporting safeguarding concerns was changed and that's the change in process we've just discussed; isn't that right?

A. That's right.

231 Q. You have given us some detail about that. Just to be clear though, the effect of that was that at that time in Muckamore the regional policy on safeguarding was no longer being applied; is that right? 15:03

A. That's right, we were working to a lower threshold, that's right.

232 Q. What was the practical effect of that? You have described how it meant that that filter mechanism by the senior ward staff wasn't there, so everything went to a DAPO, isn't that right? 15:04

A. That's right.

233 Q. Everything was then investigated, is that the outcome?

A. The DAPO may not have accepted them all for investigation, there are some that could have been screened out anyway but that was still a process of work for that DAPO to make those initial inquiries. The majority of them went to investigation and some even went as far as viewing CCTV and that could take hours just with the nature of looking at it, so that increased workload. I think the effect of that change was that probably the nursing staff, I imagine, I don't know because I never asked them, perhaps I shouldn't 15:04 15:04

speculate, but I imagine they didn't feel that they were trusted. They already had a lot of anxiety and fear around safeguarding so that maybe didn't help. It created that workload for us. It created a lot of anxiety for families who perhaps felt that everything was at a more serious level than it actually was. And I think it created anxiety certainly for the more able patients who had an understanding of there being an investigation. 15:05

So in hindsight, although at the time I can understand that it may have seemed like a good idea, I think in hindsight it perhaps created more difficulties than it solved. 15:05

234 Q. You referred there to the speculation that nurses may have felt that they weren't trusted, what in particular makes you say that?

A. Because these decisions that they previously made about screening things at section 2 as it's known of the ASP1, had been taken away from them and that may or may not have been the right decision. But I think the impact for them can only have been that there was perhaps some resentment and some feeling of not being trusted to make a decision that they had done previously. 15:06

235 Q. You mentioned also there an effect on some of the patients who had some level of understanding of the safeguarding process, can you describe what sort of effects it had?

A. The patients probably didn't know the DAPOs as well as they knew the ward staff, and especially ward staff that they had positive relationships with. So by a DAPO taking all these referrals in and beginning to investigate them meant that the patient was having to recount the experience again and again with someone that they new less well and probably had a less positive relationship with and I imagine that could well have increased anxiety and frustration for them. 15:06

236 Q. CHAIRPERSON: Could I just ask while we are on that, does the lower threshold also apply to what you were reporting to the PSNI? 15:07

A. I'm not sure I understand, Chair.

237 Q. CHAIRPERSON: You described how there was a lower threshold, so more was being referred? 15:07

A. Oh, I understand now, no, the policy lays out strict criteria for what is reported to the police, and that was always followed. If we had any doubt about something that should be reported to the police they were very receptive to a phone call to run it by them and they would make a decision and let us know if they wanted a referral form. 15:07

238 Q. DR. MAXWELL: Do you think when you came into post and introduced this new system that the number of referrals to PSNI went up? 15:07

A. Without knowing what the referral level was before I came into post, I don't know. But I imagine it probably was higher at that time than before what we knew, before what happened in 2017 came out, it

probably was.

239 Q. DR. MAXWELL: You had no feedback, nobody ever commented?

A. No-one ever commented, no. I do know that the police officers would have commented to us that they were kept incredibly busy with Muckamore referrals as well. 15:08

240 Q. PROFESSOR MURPHY: You did say that you started to collect a database of ASG referrals?

A. That's right.

241 Q. PROFESSOR MURPHY: Was there none before your arrival, was nobody else looking at trends? 15:08

A. There was no central database where there was an ability to look back, say, over a month's referrals and identify a trend. It probably would have involved, to do that, it probably would have involved just someone sitting down with all the referrals and looking at them. When we implemented that database we were then able to filter and to see where there was commonality. 15:08

242 Q. DR. MAXWELL: Would that not go in the annual report as the delegated duties that the Executive Director of social work had to report? 15:09

A. It wouldn't go into the level of detail that would tell us where there was a pattern. For example, one of the patterns that identified very quickly was that when the patients came back onto the ward from day care they were all coming in at the same time, all coming through the same door and they were processing through a particularly narrow part of the ward, this was Cranfield ward and they were probably hungry, tired and 15:09

that often resulted then in some arguments or in patients hitting each other. So that was very easily identified and then we could try to take steps. But those reports at that level wouldn't go into that detail. 15:09

243 Q. DR. MAXWELL: I think just to clarify, the Trust would have known because it is part of it's delegated statutory duty?

A. Yes, delegated functions.

244 Q. DR. MAXWELL: You were collecting more detail, it's not that it hadn't been collected before? 15:09

A. Adding more detail. Much more detail.

CHAIRPERSON: I am just thinking about timing. Is this a good time or do you want to finish this topic?

MS. KILEY: I think if we finish this topic, I only have a couple more questions. Are you okay to continue? 15:10

A. That's fine.

245 Q. MS. KILEY: Thinking in terms of the size of your team, whenever you first started there was you and two others; is that right? 15:10

A. There was myself and one other, H283.

246 Q. And then a third person --

A. Then a third person was added some time after.

247 Q. When was the third person even roughly added? 15:10

A. If I started in September it would have been after Christmas, so possibly early in 2020.

248 Q. Was that addition a recognition by the Trust?

A. Yes.

249 Q. That there was a heavy workload?
A. It was because I was raising the sheer amount of workload, yes, so they created another post.
250 Q. Who had you raised that with, not giving me specific names but levels? 15:10
A. With my supervisor and with my line manager.
251 Q. And you said at paragraph 21 you give us some statistics and you said that in the normal course of things working the regional policy one DAPO should have been enough for Muckamore and you explain that 15:11
Muckamore in effect had three DAPOs for approximately 50 patients at that time. So that's a ratio of around one DAPO to 16 to 17 patients. But you also say that the community teams had four DAPOs for approximately 1,500 patients? 15:11
A. That's right.
252 Q. Again that's a ratio of about one DAPO to 375 patients so you can see by those statistics that there is a stark difference in the numbers?
A. Correct. 15:11
253 Q. What do you think the reasons were for that?
A. For there being so many DAPOs in Muckamore?
254 Q. Yes?
A. Obviously the nature of patient, at the time they were probably more ill, more complex than the people the 15:11
community teams were supporting. And because that level or that threshold had gone so everything was going to a DAPO so you need more DAPOs. But we were also looking at historical things, so you need more

DAPOs. But it always struck me as strange that the -- I accept that the patients in Muckamore may well have been more complex and presented with more challenging issues, but that doesn't necessarily follow that the clients being supported in the community were at any less risk. Sometimes some of those people were living very risky lives and needed a lot of input, but all this input was going into Muckamore. And I understand that with the anxieties around about safeguarding at the time and everybody trying to make it better and do it right, that perhaps seemed like the right thing to do at the time but my experience was that it didn't work well. 15:12 15:12

255 Q. And you refer to, you describe it as being very process driven. You refer to having raised the concerns and then that led to a third member being added to the team. Once that third member was added did you continue to experience that overwhelming workload? 15:13

A. I suppose it got slightly better because we had a third person there but it was still far too much for those three people with no admin support and the sheer amount of work and paperwork and all those meetings and all those documents that had to be completed all the time, it was still a huge amount for three people. 15:13

256 Q. Did you continue to raise -- 15:13

A. I did.

257 Q. Who did that raise it with?

A. My line manager and supervisor.

258 Q. And what response were you given whenever you were

raising those issues?

A. They agreed with me and my understanding is that they both raised it with senior Muckamore management but I didn't see any change.

259 Q. And were you ever given a reason as to why no change was happening on the ground? 15:14

A. No.

260 Q. You mentioned there just the various meetings that you referred to and you've referred to them in detail in your statement, I won't go through them, but suffice to say there was a long list there. One example of just one category of meeting you suggested could result in around 25 meetings a week. But you do then say ultimately despite all those meetings you felt you weren't being heard and weren't making progress. Are you saying that the meetings themselves were ineffective? Are you saying there is an issue with the volume of them? 15:14 15:14

A. I think the meetings in themselves were ineffective. Probably an issue with the volume as well because I think you can become saturated with meetings and people switch off, it is just meetings for the sake of meetings. But I don't think they were effective probably because they weren't particularly well attended and because not everybody necessarily understood the point or understood their role. I think very much safeguarding was seen as something that belonged to the social workers and other people didn't necessarily see their role in it. I think the other 15:14 15:15

difficulty with it was that there were limited options in Muckamore I suppose for what could be done. The nature of the patients, trying to separate them, trying to move them on to different wards, that was a challenge and the staffing issues at the time were also, that was also a challenge. So I think for all those reasons it wasn't really effective.

261 Q. And just then to conclude this issue about workload, which you have described as overwhelming, what measures do you think could have been taken to alleviate the pressures that were on you and the ASG team at the time? 15:15

A. I think we probably needed to have an honest look at how the thresholds were being applied and consider how useful that was and if there was a better way to do things. I think to do that most effectively it would have needed to be done in collaboration with the Muckamore staff and not just the senior staff but with the staff at ward level as well who were having to on a day-to-day basis make these referrals through and then try to manage what we were recommending be done on protection plans. 15:16

262 Q. Did you not have an opportunity to have those kinds of discussions when you were in post?

A. We had those discussions at all these various meetings but just nothing ever seemed to change. There seemed to always be so much going on that we said things and we agreed to talk about it again but progress didn't happen. 15:16

MS. KILEY: I want to move to the next topic now but I am conscious of the time and I think now might be appropriate time?

263 Q. CHAIRPERSON: Can I just ask who was chairing those meetings? 15:17

A. Depending on which meeting it might have been, the divisional nurse chaired the ward manager's meeting, I chaired the safeguarding forum. One of the DAPOs chaired the ward based meetings about protection plans, so any one of those people. So that would have been 15:17 from Band 7, up.

264 Q. CHAIRPERSON: Right. And when you made complaints about a lack of admin support or even a lack of an office, it sounds as if you didn't have your own office. Do you know if that was being raised with the 15:17 Muckamore management?

A. I raised it with Muckamore management and was told we'll look at that but nothing ever changed.

265 Q. CHAIRPERSON: Over what period?

A. I probably had a few months where I was just bedding in 15:17 and seeing how things were progressing but I would imagine from after Christmas on I was raising these issues. I would have spoken to H300 on a fairly regular basis about issues, just didn't really seem to get anywhere. 15:18

266 Q. CHAIRPERSON: At some stage in your statement you refer to working in a corridor?

A. In the DAPO office which was big enough for two people and this is also during Covid so there were

restrictions on how many people could be in an office, I often just sat in the corner of that office with a laptop on my knee. I sometimes sat in my car in the car park with a laptop on my knee or I went to the Everton Complex on the Crumlin Road. But I preferred to be on site because I felt that safeguarding needed to be really visible.

CHAIRPERSON: We'll take 15 minutes, I think. You will be looked after and given a cup of tea or whatever you need. We'll try and come back at about 3:40. Thank you very much. 15:18 15:19

THE HEARING ADJOURNED FOR A SHORT PERIOD.

THE HEARING RESUMED AS FOLLOWS: 15:38

267 Q. MS. KILEY: Thank you, A3. I'm going to move on to another topic but, before I do, I understand that you have alerted the secretary to the fact that you have thought of something else in answer to Dr. Maxwell's question earlier about protection plans and their storage and would you like to bring that to the attention of the Panel? 15:40

A. Yes it was just to point out that the more junior members of staff on the wards, Band 3, Band 4 staff wouldn't have had access to PARIS to the electronic recording system at the time so they would have no way of going on and seeing care plans there to the best of my knowledge. So that blue folder would have been the 15:40

possibly the only way they would have seen the protection plan.

268 Q. DR. MAXWELL: So how would they have seen the rest of the care plan?

A. I don't know, I didn't work in that capacity. 15:40

269 Q. DR. MAXWELL: We have heard from other witnesses that there were other paper documentation as well?

A. Yes.

270 Q. MS. KILEY: Thank you for you that A3, I am going to move onto the second topic that was identified as a 15:40 challenge in your role and that is staff attitudes to safeguarding at Muckamore. And you deal with this first in particular at paragraph 9 and in fact you say that your first impression when you took up the role was negative and you go on to say that you felt you had 15:41 a lot do to bring staff on Board and you're not sure that there was buy-in from staff.

A. Mm-hm.

271 Q. Can I just ask you to identify first when you refer to staff in that general sense, what kind of staff are you 15:41 referring to?

A. I think really everyone who worked in the hospital, although my dealings primarily would have been with the nursing staff and the nursing assistants, although I don't think anybody in the hospital particularly was on 15:41 Board with safeguarding.

272 Q. One of the other things that you describe is that staff were unnecessarily defensive?

A. That's right.

273 Q. In your words. Can you explain a little bit more what gave you that impression?

A. Well the fact that attendance at meetings was poor, that whenever my colleagues and I would have went on to a ward we would have seen people maybe roll their eyes at us, walked out of rooms if we walked into them. We heard whisperings. So it was incidents like that that left us all feeling that they were defensive and whenever we did, if we were investigating a safeguarding incident and we were talking about protection plans, the language coming back about you don't understand, and we can't do that would have given that impression. 15:42

274 Q. You do say that you felt that the atmosphere and the approach depended on the ward manager and nurse in charge? 15:42

A. That's right.

275 Q. Is it fair to say there were different attitudes across different wards?

A. That's right, yes. 15:42

276 Q. Is that always the case whenever you are dealing with safeguarding in a hospital context, the person in charge of a particular ward will steer the direction of the staff on that ward to an issue?

A. I have only worked in safeguarding in that one hospital so I couldn't comment in other hospitals but, yes, I think leading by example and bringing all your staff along with you is very important, so I think it would have been important for the ward managers and the staff 15:43

above them to be showing that leadership. I'm not sure it was always shown.

277 Q. You do describe the different approaches of particular wards, som for example, at paragraph 13 you refer to Cranfield ward as being an example of a ward that had a better understanding of the processes or more confidence in the decision making. So is the Panel to take it then that that during the time period that you can speak about Cranfield was in the main effectively following safeguarding procedures? 15:43

A. There were two Cranfields, Cranfield 1 and 1. I'm not sure which one this manager was over, I just can't remember now, but this particular person, H67.

278 Q. Yes?

A. I just felt that he, he seemed to be quite open and receptive and he very often would have come over to the safeguarding office and asked what he could do or asked for general advice and he was very receptive to us coming onto the ward. Whenever the database identified the issue with meal times and patients getting frustrated and hitting each other because they were all funneling through that tiny area, it was a tiny step but he was very proactive in separating out the tables and chairs and trying to create more space. He demonstrated he was listening and he was taking it on Board. I felt we had a positive impact on that ward and from that manager. I just don't think I got the same response from other wards. 15:44 15:44 15:44

279 Q. One of the others that you do refer to is Ardmore and

you refer to it in your statement as being a ward that caused you concern. What was it about what was being done on Ardmore that caused concern?

A. Silence I think. In complete contrast to H67, the staff there weren't engaging with us. They didn't pick up the phone or come over and speak to us. And when we did go on to that ward that feeling of interference seemed to be quite present. There were other times we walked onto the ward and were impressed to see craft activities or beauty sessions going on. But if we were there to talk about safeguarding it seemed to be a sigh, so just the level of engagement was very different. 15:45 15:45

280 Q. And in terms of your access to the wards, would you have had to give wards prior notice that you were attending on ward or did you have free access? 15:45

A. Whenever I first arrived at Muckamore we had to go knock the door, ring the bell and be let in. It was then arranged that our ID passes would have the access so we could walk in. If a ward was particularly unsettled though, we might have, if we had knowledge of that we might have rang ahead and said coming over, has that settled down because the last thing we wanted to do was to upset anyone. But once we had that access we could just walk on to a ward, yes. 15:46 15:46

281 Q. You have mentioned in your statement and in our discussions Cranfield and Ardmore in particular. Are there any other particular wards that stand out either as causing you concern or as examples of good practice?

A. Erne was different again in that there seemed to be a very high level of anxiety on that ward. That didn't really concern me too much though because that ward manager, and there isn't a cipher for that person, was anxious but she always picked up the phone to say what do you think about this, and I would always rather that someone pick up the phone and have the conversation rather than they get something wrong. So although maybe that level of anxiety was concerning and I was certainly concerned for the level of stress that lady appeared to be under, at least I knew she picked up the phone. 15:46 15:47

282 Q. And so, you seem to be gauging the level of concern or the level of contentedness with particular actions with the ward's level of engagement with you, is that right? 15:47

A. Yes, very much so, yes.

283 Q. And you were ASG lead, were you able to take any steps to ensure consistency in terms of the approach of ward managers and how they would engage with you?

A. I suppose we, I went to that ward manager's meeting once a month and the first half hour of that would have been given over to myself or my colleague to explain whatever issues were coming up to give some feedback on good practice and the hope that then that could be discussed and would be filtered through everyone and also to pick up on issues of concern, so there was that. There was also the ongoing sessions that my colleague, H283, was providing on the wards on how to recognise concerns and how to complete referrals. And 15:47 15:48

just the fact that we tried very hard to be approachable and to always have an open door policy. My colleague in particular was very skilled at that, she had a very friendly and open approach and I always thought she was very skilled at trying to break down barriers and bring people with her.

284 Q. Aside from those sorts of interactions, if you did encounter inconsistencies or approaches from certain wards or certain members of staff that were causing you concern, what did you do to escalate that beyond ward level? 15:48

A. So there were three assistant service managers, three senior Band 8A nurses, I would have discussed it with them, we had a monthly meeting as well. I also would have raised it with my line manager, with the supervisor and with the divisional nurse when I had conversations with her. 15:49

285 Q. What effect did that have, that raising it at that level?

A. None. I maybe wasn't there long enough for to see much effect but I don't recall seeing any change. 15:49

286 Q. And even if you didn't see change, whenever you were raising the issues at that level what sort of feedback were you getting on them?

A. About staff anxiety and staff fear around the whole safeguarding process. And because the police investigation was so large and ongoing and staff continued to be suspended, that's bound to have been having an effect on staff anxiety and maybe a feeling 15:49

that we were adding to that because we were continuing to investigate things. There just seemed to be so much tension around all the time.

287 Q. In terms of tension, one of the other things that you describe at paragraph 26 of your statement is that senior management in Muckamore often disagreed with your safeguarding decisions. Was that a source of tension? 15:50

A. It was a source of frustration and concern for me, certainly tension for me and it was one that I raised with my line managers and it was ultimately the reason why I left. 15:50

288 Q. Just to clarify whenever you do refer there to senior management disagreeing with your decisions, what level of management are you talking about there? 15:50

A. ASM, co-director, that level.

289 Q. CHAIRPERSON: Is that sitting in the Trust?

A. They would have been Muckamore staff within the Trust.

290 Q. CHAIRPERSON: Under the umbrella of the Trust, I understand that, but where were they situated? 15:51

A. Muckamore.

291 Q. DR. MAXWELL: The co-director would have been for the division or the directorate, wouldn't they, so they would have been responsible for Muckamore and mental health services? 15:51

A. Yes, that's right.

292 Q. MS. KILEY: You do say, A3, on a couple of occasions in your statement that you feel uneasy about providing names. You have provided roles there?

A. Mm-hm.

293 Q. I don't want to ask you to provide in public individual names, but could you tell the Panel a little bit more about why you feel that unease?

A. Well I have, I no longer work for Belfast Trust so perhaps I shouldn't, but I think it's natural to feel anxiety about being critical of colleagues at all and especially about very senior colleagues. It is just something that it's a position I wish I had never been put in and it is a position that still upsets me when I think about it. Sorry. 15:51 15:52

294 Q. That's okay, just take a moment?

A. I mean I don't have any fear of anything negative, definitely not, but it's just not something I thought I would encounter in my career, certainly not whenever my role was not only about safeguarding patients and trying to make those processes better but that actually in a way is also about protecting staff because if staff are conducting themselves properly and engaging with safeguarding processes and working collaboratively with us, then they are protected from false allegations or from some level of stress because they can say I'm working within this framework, I'm taking this person's advice. So it seemed very strange to me that what I really believed I was doing was trying to help everyone and yet that didn't seem to be understood. So I just naturally still am anxious about talking about it or naming people. 15:52 15:52 15:52

295 Q. And that's now, but back whenever you were carrying out

the role, did it also make it difficult to raise your concerns at higher levels?

A. It did in that I had to think about what I was going to say and when I was going to say it, but I still said it. I was just very clear that this is my role, these are my responsibilities and this is my role. Usually when someone disagreed with me, I had already done it, I had already made the referral to the police. Staff knew, senior staff knew what was the concern was because if it was an allegation about staff they were informed at a very early stage. It was just that maybe someone came back and said well, I'm not sure why you did that or I don't agree with that but it was too late because I had already done it or my colleague had done it. But just left with that bad taste that you were then unpopular but it was the right thing to do. It was the only thing do because it was my job and it was policy. 15:53 15:53 15:54

296 Q. CHAIRPERSON: Can I just ask, were they coming back to you and challenging -- is there an element of subjectivity in all of this in terms of a referral, just by way of example? 15:54

A. Not whenever there were referrals to the police. There was very clear criteria about referrals to police and it is basically if you know or suspect there is a criminal offence that it goes to the police. And it is the DAPO's decision to do that and the DAPO's alone. What happens then is an officer in the Public Protection Unit will call the DAPO and they will have a 15:54

conversation around the best way to manage this. And sometimes the police will say this isn't for us, and that's okay, and sometimes it absolutely is for them. And it just distressed me that having made that decision, having had the police agree that this was something they wanted to look at, that a senior manager would then say I don't agree with that.

297 Q. CHAIRPERSON: And that did happen?

A. That did happen.

CHAIRPERSON: There are specific examples you can remember. 15:55

A. There are specific examples of that happening.

298 Q. CHAIRPERSON: Of referring something to the PSNI, them accepting it and then being challenged by senior management to say that was the wrong decision? 15:55

A. Yes.

299 Q. PROFESSOR MURPHY: Was there pressure from them always to always refer less to the PSNI, was it always in that direction or did they sometimes feel you should have referred something to the PSNI when you didn't? 15:55

A. I'm sure there were occasions when they absolutely agreed that things should have been with PSNI, but there were definitely occasions whenever they disagreed and would have asked why did you do that, I don't think so. There is one particular example I give in my statement. 15:55

300 Q. MS. KILEY: When that occurred and senior management did disagree, did they explain their reasons to you for the disagreement?

A. No.

301 Q. And you refer to making police referrals, can you recall in the time period that you were in role was there ever an occasion where you made a referral to PSNI and PSNI came back and said this is an inappropriate referral? 15:56

A. They wouldn't have said inappropriate but they might have said this doesn't meet threshold, we're not looking at this. My understanding at the time though was that the police were also working to a lower threshold given what they knew, and were perhaps taking more on than they might have. That's just my feeling, I don't have anything concrete about that. They wouldn't have said inappropriate. I think they were always more than happy for myself or my colleagues to pick up the phone and have that conversation. 15:56 15:56

302 Q. And when these disagreements occurred and you were clearly unhappy about them, were there opportunities for you to escalate those concerns about those senior managers? 15:57

A. Some were so senior that that would have been very difficult.

303 Q. Were they things that you could discuss with your line manager?

A. I did discuss with my line manager and my supervisor. 15:57

304 Q. And did they do anything about the concerns, could they take action?

A. Not that I know of, I don't know if they did or not.

305 Q. But your line manager and your supervisor, how would

they have sat in the hierarchy in terms of as compared with the people who you had concerns about?

A. Either on a level or just below.

306 Q. Were you aware of whistle-blowing policies within the Trust? 15:58

A. Yes.

307 Q. And having developed concerns about senior management, did you consider engaging with whistle-blowing policies?

A. I don't think I did because I had raised the concerns through my own managers. 15:58

308 Q. Did you ever get feedback from your own managers or supervisor?

A. No, other than to know that my supervisor was frustrated as well. 15:58

309 Q. Can you give the Panel an indication of how often this was occurring, how often disagreement was occurring and how often then you would you have raised that with your line manager?

A. It is very hard to say how often but I can think of two incidents, one that I describe in my statement and one that I haven't referenced, where the question was asked why did you do that, we don't think that's right. 15:58

310 Q. You mentioned there whenever you were answering one of my questions about senior managers would have been aware at an early stage about referrals that were made in respect of staff. So does that mean then that all adult safeguarding referrals for MAH that related to staff were sent to senior management in Muckamore? 15:58

A. Yes, because they had to make the decision as to whether that member of staff could remain working on the ward or needed to do another job or needed to be suspended.

311 Q. Is it right to say then that wasn't as part of the safeguarding process but as part of a different process? 15:59

A. That's right, that sat outside my role.

312 Q. You did refer also in your statement to a live governance meeting and that happened weekly. That was attended by the Clinical Director; isn't that right? 15:59

A. The Clinical Director chaired it.

313 Q. Was that a forum in which you could raise concerns such as this?

A. It was a meeting that took place over the telephone, it was pre everybody really getting on to Zoom because of Covid. So it took place on conference calls and I think they are always difficult because you don't know who is speaking and when it's your chance to speak. But safeguarding was raised then and the Clinical Director would have made a point of asking myself or my colleagues are there any safeguarding issues and that was a chance to say there are so many referrals, this is what the concern is. 15:59 16:00

314 Q. And that sort of example is, I suppose, more in line with the first topic that we talked about in terms of volume, would you have felt able to raise concerns about the attitudes of staff, either ward staff or senior staff at a meeting like that? 16:00

A. No, because those staff would have been present at that meeting and there would have been ward managers or deputy ward managers at that meeting.

315 Q. You did refer also to leaving your role and you say in your statement that you left your post after one year. 16:00
In fact at paragraph 33 you say that the fact that you left after one year demonstrates that you did not feel that the new procedures were working or that you would be successful in your role. And you go on to say that you had no confidence that attitudes and culture in 16:01
Muckamore embraced adult safeguarding. How would you describe the culture in Muckamore during the time which you were Adult Safeguarding Lead?

A. Defensive, I think defensive is the best word. There was, there seemed to be a strong belief amongst staff 16:01
that the whole police investigation was about poorly used MAPA and that safeguarding were making a bit of a song and a dance about MAPA that just wasn't well used and in the context of a patient being particularly challenging that should be understood. We couldn't put 16:01
them straight on that, of course, and I actually didn't know that much detail to put them straight but I knew it wasn't about poorly applied MAPA. So I think defensive is the best word. It was you are coming in here and telling us what to do and what do you know was 16:02
kind of the feeling I got.

316 Q. CHAIRPERSON: Is that the word you are just applying to staff or does it include --

A. No, I would include it to the senior levels as well.

317 Q. MS. KILEY: And you think that that defensiveness arose from the ongoing investigations, is that what you're linking it too?

A. To the staff's misunderstanding about the ongoing investigations, the very senior staff obviously would have known exactly what the investigations were about. And I understand that they also had a job to do with trying to stabilise a hospital that was in crisis and had huge staffing difficulties and trying to improve the staff morale. But there seemed to be a real struggle to do that with safeguarding as part of it. It seemed to be, could you do one or the other but you couldn't do both. 16:02 16:02

318 Q. Defensiveness is a word that you used in your statement as well, but another description that you gave in your statement was that you had the impression that Muckamore staff didn't feel that safeguarding was part of their role. What did you mean by that? 16:03

A. I think safeguarding is very often seen to be something that social workers do, it's not and it shouldn't be. I think if it was something that didn't appear to be very blatantly, for example, somebody being punched and seriously hurt, they couldn't see that anything below that was still safeguarding. 16:03

319 Q. One of the other ways you describe it, as you say, "there seemed to be an unwillingness to really do what needed to be done". What was it that needed to be done? 16:03

A. Well, for example, to go back to the example about

mealtimes when we asked about separate sittings to alleviate some of the tensions, it was just a point blank no, that can't be done. The meals weren't cooked on site, they were brought in and reheated so I understand there were challenges around that but there was no effort to explore it, it was just no it can't be done. So the furthest we got with that ward manager separating tables out. When we asked about patients being separated to different ends of the ward or having their rooms separated, no, that can't be done because he can't go near him and she can't go over there. And I understand that there were all sorts of issues with the patient acuity and who could mix with someone else, but there seemed to be little in the way of imagination for how else can we do this with the result that those, I am going to say lower level and that's not to minimise anything, but those incidents when patients were feeling unsafe because another patient was shouting at them or hitting them or touching them and they didn't want to be, were almost tolerated because well, we can't do anything about this and it shouldn't be tolerated. 16:04 16:04 16:04 16:04

320 Q. In fairness in your statement you do say that there was some success?

A. Yes. 16:05

321 Q. What would you count as the successes?

A. Well that ward manager who wanted to, and did move tables around. Some staff did engage with us and made an effort to talk to us and to come over and have a

chat and say what do I do about this. But it wasn't much more than that. There was, after we implemented the database and made some changes, there was a point whenever the incident numbers seem to drop, but that wouldn't have been sustainable if those patients still remained together and there was nothing being done longer term to separate them, to address some of the issues, for example, about meal times, about boredom and lack of activity, so small successes but not enough. 16:05 16:06

322 Q. I want to show you another document. I showed you earlier on the RQIA notice from August 2019. There is a later version that I want to show you, it will come up on the screen in front of you. The first document that we looked at was reference IN00005, 16th August 2019. And then this is the second document. You can see that the reference is the same at the top but has an E beside the number 5, it does still say issue date 16th August 2019. But if you go down to the substantive box you can see it refers back to the earlier Improvement Notice, it says an Improvement Notice was issued to the Belfast Trust on the 16th August. 16:06 16:06

"The Improvement Notice was issued as a result of the Trust failing to ensure and evidence effective safeguarding arrangements are implemented and assured within Muckamore Abbey Hospital as identified during inspections in February and April 2019." 16:06

It goes on to say:

"Following the issue of the Improvement Notice we met with representatives from the Trust on 2nd October 2019 to receive an update regarding progress towards compliance with the actions outlined in the Improvement Notice on 16th August 2019. The information shared with RQIA during this meeting provided assurances that the Trust understood its responsibilities with respect to adult safeguarding practices in MAH and had a programme of work in place to address requirements set out in the Improvement Notice. We undertook an unannounced inspection of MAH from the 10th to 12th December 2019. Our inspection team evidenced significant improvements in relation to adult safeguarding in MAH. We determined that there was effective deployment of safeguarding referrals, implementation of learning arising through safeguarding investigations and that outcomes from safeguarding investigations were positively impacting patient wellbeing."

16:07
16:07
16:07

There is reference in the next paragraph to evidence of good multidisciplinary working and you will see reference to meaningful implementation of protection plans being achieved. It says:

16:08

"The quality and timeliness of information on

safeguarding concerns was being shared with relevant stakeholders and was improving. We were assured the service improvements outlined had been developed through meaningful engagement with patients, carers and staff. We determined that Trust staff now have clear understanding of their roles and responsibilities with respect to safeguarding practices at ward level, at managerial level and at a governance level within the Trust." 16:08

16:08

And they refer to auditing and then they say:

"As a result of improvements RQIA determined to lift all elements of the Improvement Notice except for the action to implement effective mechanisms to evidence and ensure its compliance with good practice in respect of adult safeguarding across the hospital." 16:08

That's extended for three months. You can see then over the page it says the date the compliance must be achieved is the 19th March. 16:09

There is no date on that but by the reference to three months and date of 19th of March it appears that was perhaps in and around January 2020. Have you seen that document before? 16:09

A. I don't recall seeing it, no.

323 Q. There is reference there to the unannounced inspection of the 10th to the 12th December 2019. You were in post at that time, isn't that right?

A. I was.

324 Q. Do you recall that unannounced inspection?

A. I do, I recall speaking to an inspector.

325 Q. You can see there, there is some -- RQIA have identified improvements as they call it. In fact they refer to significant improvements and they refer to evidence of good multidisciplinary working, they say that staff had a clear understanding of their roles and responsibilities. Was that your experience of safeguarding at Muckamore Abbey Hospital? 16:09 16:10

A. Some staff would have had a better understanding and would have been able to answer the Inspector's questions positively. Other staff definitely wouldn't have. My overall impression was that things were better by December, by March than when I first came into post but they still weren't good enough and I was still facing challenges and challenges significant enough that I felt I had to leave. 16:10

CHAIRPERSON: Can you just remind me what is the date of this report, it is pre-March isn't it? 16:10

MS. KILEY: There is no date on it in fact, Chair, but if you look at the back page it says the date upon which compliance must be achieved is the 19th of March.

CHAIRPERSON: That's obviously forward looking.

MS. KILEY: It's forward looking. There is no reference to a date, the front cover page refers to an issue date of the 16th August 2019 but we know that that is the issue of the original Improvement Notice. 16:10

CHAIRPERSON: It is somewhere in between the two isn't

it probably?

MS. KILEY: There is reference to an inspection having taken place after the 10th and 12th December so it must have been after that time.

326 Q. CHAIRPERSON: This is really right in the middle of your period because you started September 19? 16:11

A. Started September and left in October '20.

327 Q. CHAIRPERSON: So this is really towards the beginning of the period you have been describing?

A. Yes, so I think we did make some positive changes and not least because my colleague was so active in the support sessions that she was offering to staff and those folders I mentioned on the ward so that staff, if an Inspector came onto the ward they could pick it up and say yes, I know there is protection plan for this patient. I just don't think it was sustained or sustainable. 16:11 16:11

328 Q. MS. KILEY: Whenever you were describing leaving your post in your statement, you said that you didn't feel professionally safe. What do you mean by that phrase? 16:11

A. Because my role was very specifically around making these decisions and my other DAPO colleagues' roles was specifically around making these decisions. Yet I knew that some senior staff in the hospital were expressing disagreement with that and whenever I, as referenced in the example I gave, offered to explain, nothing happened, I wasn't taken up on the offer. So I just felt it was completely untenable to stay. 16:12

329 Q. When you did leave did you have an exit interview or

anything of that kind?

A. Not at the time.

330 Q. Have you had one since?

A. I had one perhaps a year, 18 months later.

331 Q. Was that an opportunity to raise your concerns? 16:12

A. And I did.

332 Q. And have you had any feedback from that?

A. No.

333 Q. Okay. And the concerns that you raised in the exit interview, are they the concerns that you have raised 16:12 with the Inquiry today?

A. Yes.

MS. KILEY: Those are all my questions on the open part of your evidence, there is a paragraph that we'll return to deal with but the Panel may have some 16:13 questions?

334 Q. CHAIRPERSON: Before I turn to my colleagues, can I just ask, are you the only DAPO who left?

A. H283 retired. I don't know what happened to the other lady, I don't know if she remains or not. 16:13

CHAIRPERSON: Thank you, I'm sorry, I should have turned to my questions.

PROFESSOR MURPHY: No, I don't have any.

CHAIRPERSON: Can you just give me a second, sorry? No I think we have covered everything, thank you very 16:13 much. We are now going to turn, unless there is anything else, we'll now go into restricted session just to deal with that one paragraph. So could I ask for the feed to Room B please to be cut. Only those

who have signed confidentiality agreements shall be watching, I know the secretary will confirm that, so we are now in restricted session.

RESTRICTED SESSION 16:14

THE HEARING ADJOURNED TO THURSDAY 16TH NOVEMBER 2023 AT 10:00 A.M.