MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 12TH DECEMBER 2023 - DAY 72

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APPEARANCES

CHAIRPERSON:	MR. TOM KARK KC
INQUIRY PANEL:	MR. TOM KARK KC - CHAIRPERSON PROF. GLYNIS MURPHY DR. ELAINE MAXWELL
COUNSEL TO THE INQUIRY:	MR. SEAN DORAN KC MS. DENISE KILEY BL MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MR. JAMES TOAL BL MS. RACHEL BERGIN BL
INSTRUCTED BY:	MS. LORRAINE KEOWN SOLICITOR TO THE INQUIRY
SECRETARY TO THE INQUIRY:	MS. JACLYN RICHARDSON
ASSISTED BY:	MR. STEVEN MONTGOMERY
FOR ACTION FOR MUCKAMORE & SOCIETY OF PARENTS AND FRIENDS OF MUCKAMORE:	MS. MONYE ANYADIKE-DANES KC MR. AIDAN MCGOWAN BL MR. SEAN MULLAN BL
INSTRUCTED BY:	PHOENIX LAW SOLICITORS
FOR GROUP 3:	MR. CONOR MAGUIRE KC MS. VICTORIA ROSS BL
INSTRUCTED BY:	O'REILLY STEWART SOLICITORS
FOR BELFAST HEALTH & SOCIAL CARE TRUST:	MR. JOSEPH AIKEN KC MS. ANNA MCLARNON BL MS. LAURA KING BL MS. SARAH SHARMAN BL MS. SARAH MINFORD BL MS. BETH MCMULLAN BL
INSTRUCTED BY:	DIRECTORATE OF LEGAL SERVICES
FOR DEPARTMENT OF HEALTH:	MR. ANDREW MCGUINNESS BL MS. EMMA TREMLETT BL

INSTRUCTED BY:	MRS. SARA ERWIN MS. TUTU OGLE DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DWF LAW LLP
FOR PSNI:	MR. MARK ROBINSON KC MS. EILIS LUNNY BL
INSTRUCTED BY:	DCI JILL DUFFIE

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THE INQUIRY RESUMED ON TUESDAY, 12TH DECEMBER 2023 AS FOLLOWS:

CHAIRPERSON: Good morning, I think that is a first, we are actually starting a minute early. 09:55

MR. MCEVOY: End of year so we will keep going.

CHAIRPERSON: Right, are we ready with the witness?

MR. MCEVOY: We are.

CHAIRPERSON: I've got a few words that I'll say but I'll say those obviously at the end of today's 09:55 evidence, okay. Shall we get the witness in.

MR. CAHAL MCKERVEY SWORN, QUESTIONED BY MR. McEVOY:

CHAIRPERSON: Good morning, welcome to the Inquiry. 09:56 Thank you very much for coming to assist us and I'll hand you over to Mr McEvoy.

1 Q. MR. MCEVOY: Good morning. Just begin by stating your name, please, for the Inquiry?

A. My name is Cahal McKervey. 09:56

2 Q. In front of you is a statement dated 28th of November of this year. I am going to read that statement into the record and then there will be a few matters I'd like to cover with questions.

A. No problem. 09:57

3 Q. "My connection with Muckamore is that I worked at the hospital as an agency worker on a part-time basis. The agency was Axis Nursing Agency, Belfast. The relevant time period that I can speak about is between October

2019 to the present date.

I am a registered mental health and general nurse. I qualified in April 1983 and retired in December 2018. I remain on the live register and currently work part-time as a bank nurse for the Belfast Trust. 09:57

I became a manager in mental health services for the Belfast Health and Social Care Trust, ("Belfast Trust") in 2008 and held that post until 2017. This was a Band 8A post. I worked in acute admissions services which was spread over three sites, the Mater Hospital in Belfast, the Windsor House Psychiatric Hospital in Belfast and Knockbracken Health Care Park Hospital in Belfast. 09:57 09:58

There were approximately 138 beds across the Belfast Trust Mental Health Services and these provided for either detained or voluntary patients. My role was to maintain and supervise these services. There were multidisciplinary teams on each ward, on each site. There was a Band 7 post in each ward and I was their direct line manager. 09:58

From 2017 and until my retirement in December 2018, I was the interim service manager for the acute mental health service in the Belfast Trust. I was responsible for in-patient, unscheduled care, Shannon Clinical Regional Forensic Services, general hospital psychiatry 09:58

team and the home treatment team. This was a Band 8B post.

Following my retirement I did some project work, one or two days a week from January 2019 until October 2019. 09:59
This involved treatment and care reviews for two patients who were in in-patient mental health wards in the Southern Health and Social Care Trust. In or around 2019 Muckamore was in the media regarding a criminal investigation into the treatment and care of 09:59
patients at Muckamore. I had heard from other colleagues that staffing levels at Muckamore were low and that it was difficult for the staff who were working there. This was more of a general awareness than knowledge of any specific issues or incidents. 09:59

In the Belfast Trust, the director of nursing, Brenda Creaney, had circulated an internal assurance document with questions about complaints and reporting mechanisms which I understand was as a result of issues 10:00
arising at Muckamore. This was to ensure that complaints and issues were being dealt with properly and effectively within the Belfast Trust. It was given to nursing staff on the wards and across mental health services. Therefore, I had a general awareness of the 10:00
issues at Muckamore.

As a result of this awareness, I decided that I would like to volunteer to assist Muckamore in whatever way I

could. I had no family or friends working in Muckamore prior to this. I e-mailed H296, director, and offered to assist if possible at Muckamore on a part-time basis. This would have been in or around late September 2019. She replied positively to my e-mail and introduced me to H394, Assistant Director of Nursing, by e-mail. She became my point of contact from then on. I agreed to work two days a week, usually on a Tuesday and Wednesday, in an administrative role. I worked at Muckamore from October 2019 until July 2022. I did not have a specific job title and I was employed through Axis Nursing Agency Belfast. I recall that there was a significant change of management around this time. Francis Rice, a retired Chief Executive and senior nurse, was asked to advise on current arrangements as was Jan McGall, Band 8C service manager, Fiona Rowan, band 8B social worker, and H315, who was divisional nurse, Band 8C. They all started around the same time as me. I worked in the administration building at Muckamore with these people.

10:00 10:01 10:01 10:01

I felt well supported in my role and that I could approach anyone, including senior management. During my time there, I had support from H300, service manager. The co-directors were H627, H234 and H301 and I felt I could have approached them if I needed to and if there were any issues.

10:02

I had no induction, other than the mandatory training I had with the agency and their Access NI checks. This involved basic life support training, information governance, resuscitation, manual handling, fire awareness and handling of complaints which was a mandatory requirement prior to employment with Muckamore. I had no job description or title. My role just evolved over the time that I worked there. I was providing advice and support services due to my previous experience of ward and system management. 10:02

I had no prior learning disability training prior to my role at Muckamore, other than as placement student nurse in and around 1982. There were occasionally learning disability patients admitted to the mental health wards, but it was very infrequent. The majority of my experience was in mental health services. 10:03

It became clear quickly that the staff were very stressed in Muckamore and seemed to be traumatised with the unfolding events in the media and reporting on the news. There were many registered mental health nurses who were agency workers, for example from England, and there were difficulties in integration. The agency staff reported being moved at short notice from one area of Muckamore to another to cover deficits in staffing numbers. The majority of agency staff were from diverse ethnic backgrounds and they were reporting racial abuse from the patients. At this point they 10:03

were advised to complete Datix reporting, the incident reporting system, so that the service could get an idea of the number of occasions that this was occurring. They also reported difficulty in getting access to PARIS records, this is the computerised record system. 10:04
This was raised at the time and resolved by the IT department. There appeared to be very few learning disability staff as most had left or had been placed on precautionary suspension pending Police Service of Northern Ireland and Belfast Trust investigations. 10:04

My first impressions of Muckamore were that it was very difficult from a staffing perspective. It was very difficult to recruit and there were a lack of learning disability nurses across the Belfast Trust. There were 10:04
a lot of mental health nurses in learning disability roles in Muckamore. There is a requirement for an understanding of the conditions associated with the care of learning disability patients and a reliance on individual behaviour support plans. I have a lot of 10:04
respect for learning disability nurses. They are very patient and understanding and need to have good resilience. However, my impressions from the outset at Muckamore were that the multidisciplinary teams and the nursing teams seemed to be very fragmented. The 10:05
services had become very preoccupied by governance and paperwork which was understandable given the circumstances.

I was taken aback with the level of assaults and incidents within the hospital. I had not previously seen such a high level in my work environments.

There was a very high reliance on documentation and minute taking at meetings. There was a large volume of paperwork with incidents happening most days. It was very difficult for the staff to manage and it was having an impact on staff morale. 10:05

10:05

There was a live governance meeting every Thursday. This was the terminology used for this meeting. Live governance meetings were chaired by the Clinical Director, either H443 or H223, and senior staff from the wards, who attended remotely and all meetings were minuted. 10:06 I cannot recall the staff members names. There would have been a summary of the previous action points at the start of the meeting. Typically there would have been an overview of incidents and adult safeguarding issues with a detailed review of adverse incidents for the previous week. 10:06 There would have been a review of any complaints raised. There was also a review of any issues relating to the use of restrictive practices. I would have attended the meetings very occasionally as I generally worked on a Tuesday and Wednesday. 10:06 I was copied into the minutes of these meetings and they were an effective way of having an overview of the previous weeks' governance issues. However, the minutes were very detailed in nature.

There were a number of incidents being referred to. In my previous roles, we may have had eight or nine incidents in a week. In Muckamore there were a lot more incidents being reported.

10:07

There was a safety briefing call each morning. It was conducted by way of a Teams call. On the call were ward staff bands 5, 6 and 7, as well as H29O, Assistant Services Manager, who was a bank staff member. The ward staff would have given an overview of the wards, 10:07
discussed any staff absence and other staffing issues for the day. Seven learning disability wards were discussed each morning, Cranfield 1 and 2, Six Mile, Iveagh Centre children's units, Ardmore, Donegore and Erne. There would have been an overview of incidents, 10:07
ASG 1 forms, contact with medical and senior management and staff gave a ward report during the Teams call, I do not recall their names.

During the safety brief, an overview of staffing levels 10:08
was given by the ward staff and staff would have been deployed around wards to cover for absences and deficits. The ward staff discussed any patient on patient assaults. I always found the ward staff to be very cooperative. There was no resistance from a 10:08
management perspective and I found that staff were always willing to help to meet the requirements of the service.

Over time my role grew and evolved. I took on some responsibility for information governance. Jan McGall was dealing with the form 81s. This was completed when the PSNI requested information on staff for possible interview as part of their investigation. I took on this task. The requests came in periodically in batches. The PSNI sent a form 81 to the Belfast Trust Information Governance Department at Knockbracken Healthcare Park Hospital. The information governance department then sent it to me to source the information at Muckamore. These requests could have been asking for a job description, supervision, previous disciplinary history of staff, contracts of employment, appraisals or similar documents. 10:08 10:09 10:09

I had to go to the Human Resources room in Muckamore to get this information, send it back to the Information Governance Department who then sent it to the PSNI. This was initially manual paper records which were then transported by post. I had no assistance from HR for this task, but the administrative staff helped. The HR function for Muckamore is based at McKinney House in Musgrave Park Hospital in Belfast, therefore, they were not on the Muckamore site. The information was usually there in the HR room but occasionally it was not. For example, appraisal documents were not always there. However, I was impressed with the level of information and the HR records that were held. Eventually I changed the process to an electronic process which was 10:09 10:09

much better. I scanned the documentation and e-mailed it to the information governance department who then forwarded it to the PSNI.

There was an ongoing parallel disciplinary process in respect of the Muckamore staff who were the subject of the PSNI investigations. Disciplinary Panels were set up. I was not involved in those but they may have asked for policies and procedures and staff files to be sent to them. The documentation was either physically held in the HR room or on the computer system. When the disciplinary process was completed I received the outcomes and I sent them to the PSNI as part of the form 81 process, for example, termination of employment letters. I was the conduit for the information and documentation but I did not have anything to do with the actual disciplinary process itself. 10:10 10:10 10:10

I had occasional dealings with the PSNI but anything that was sent to the PSNI went through the Information Governance Department. 10:11

When the PSNI wanted to view CCTV footage as part of a joint protocol process, adult safeguarding, they requested this by completing a form and sending it to the administration team in the administration building. These forms were kept in a file by the administration team. This was usually sent to the secretary in administration but sometimes to me. I would have had 10:11

to facilitate the request to view the footage. The process was that I contacted Radio Contact, an external contractor, who managed the CCTV storage room in Muckamore. They downloaded the CCTV footage on to a disc and gave it to me. I then gave it to the administrative team and the PSNI collected it from there. In my absence this was conducted by the administrative team. 10:11

As part of my role, I wanted to implement better systems and fix issues that were happening in Muckamore. I established from staff on the wards any issues which needed addressed. One of the issues was the emergency response system. There was a pager system which not did not work properly. In an emergency staff used the emergency response system and they should get assistance from a designated pager holder on each ward. However, the signals were not sending properly. I was concerned that Muckamore is quite isolated and staff needed to be quite self-sufficient in terms of being able to deal with emergencies. I do not know how long this issue was happening for. 10:12 10:12 10:12

Some of the wards at Muckamore are connected, for example, Cranfield 1 and Cranfield 2. Six Mile has two connected wards for assessment and treatment. Ardmore and Donegore are connected. The emergency response system worked within a short distance and therefore, 10:12

the staff got assistance from their own ward or the connected ward but not from others across Muckamore. The staff only got assistance from some wards after phone calls. I spoke to the ward managers, H426, the Assistant Service Manager. I had tried unsuccessfully to sort out the issue previously. I ensured that there were walkie-talkies placed on the wards as a temporary measure until extra antennae could be put in place. This took around four or five months to resolve. I do not recall any major issues being reported to me by any of the ward managers. 10:13 10:13

During my time at Muckamore I also assisted with the recruitment panels for Band 3, Band 6 and Band 7 nursing staff. I can recall sitting on approximately three panel meetings. Applications for senior positions were hard to recruit into, with frequent rolling adverts and expressions of interests being circulated. There were often no applications, particularly for the senior posts. There were very few applications from learning disability nurses. 10:13 10:14

I was occasionally asked to assist in finding information for other ad-hoc queries such as requests for information from Sarah Templar, Service Manager, the Belfast Trust public liaison for the Muckamore Inquiry. I was asked on one occasion to send information relating to an incident that was reported to me by H275, Deputy Ward Sister, on 22nd October 2019 10:14

whilst I was in post. An agency staff member allegedly over emphasised the pouring of water on a patient's head when they were washing their hair. By this I mean they poured an over exaggerated amount of water on the patient's head. The staff member was suspended from duty pending an investigation and an adult safeguarding process was initiated. A form 2 statutory notification of events was completed and sent to the RQIA. An APP 7 was completed by investigating officer from the adult safeguarding team with recommendations and an action plan, as is the usual process within Muckamore. 10:14 10:15

Overall, during my time working at Muckamore I found there to be a culture of respect between staff and that they were very patient with sometimes challenging patients in very difficult circumstances. The lack of learning disability nurses had an impact on the service provided. It is not usual practice for mental health nurses to be looking after learning disability patients. The preference and best practice is to have a multidisciplinary team in place who have experience in behaviour support. The training for learning disability nurses is different in terms of problem solving, behavioral support and management of the patients. Learning disability patients who have a life-long condition tend to be in hospital for a longer period of time, as opposed to acute mental health admissions who tend to recover quicker. Learning disability patients have more long-term interventions. 10:15 10:15 10:15

I was on the wards one or two times a day and, other than the incident that was reported to me, I did not see any abuse of patients, poor care or anything that I was uncomfortable with. I found the atmosphere on the wards to be professional, despite the difficulties of recruitment and retention. There did not appear to be any difference between attitudes of staff on wards. Given the circumstances, the staff were dedicated and resilient. I only saw staff providing good care to patients. I saw good evidence of de-escalation of patients in situations which could have developed. This was across most wards. I was impressed by what I saw and I felt the staff were not too reactive and I saw evidence that the staff knew the patients well.

10:16

10:16

10:17

I have no information to provide regarding admissions to Muckamore. I do not believe that there were any new admissions during this time, perhaps one new admission, but I cannot recall.

10:17

I did not witness any restrictive practices taking place. I had previous MAPA training. Some patients were managed in a pod environment. This would have been to protect them from potential aggression from other patients. A patient who had a pod could leave the pod when required and they were monitored closely by nursing staff.

10:17

As part of my role I took over the finance audits as

indicated in the finance policy, but this was more towards the end of my employment in Muckamore in early 2022. I conducted an audit of patient finances and property every month and sent it to the finance officer, H710, and the service manager for review. It included a review of cash sheet balance and signatures and a requirement that checks were being completed at each handover. I went on to the wards and checked that the patient records matched what was in the Bisley cabinet drawer. This could have been cash, phones, cigarettes, et cetera. I may also have noted that there were too much cash being held in the cabinet on occasions. This is an issue that I would have dealt with by speaking to the ward manager at the time. 10:17 10:18

I finished my role in Muckamore in July 2022. I worked for a short period of time conducting supervision and appraisals for bank staff at Belfast City Hospital. I currently work as bank nurse for the Belfast Trust. I work one day a week, usually 1 o'clock to 6 o'clock. 10:18

I work as a CCTV reviewer at Muckamore viewing retrospective CCTV footage. I did not receive any training for this role. There is a CCTV suite in Muckamore in the administrative building and this process is overseen by H234, the co-director of Muckamore. There are usually around 10 CCTV viewers who are a mix of registered mental health nurses, social workers and occupational health staff. 10:18

When I arrive for work I am given a time period to review, for example, 7 in the morning to 3 o'clock in the afternoon on a particular date. There is a sheet with a time period on it and I log in and review the CCTV for that period of time. There is no sound on the recording. I look out for anything of concern and I can increase the speed to four times faster than real time. This is not normally anything to report. It is very current footage, around three weeks ago. If there were was an incident to report this would trigger an immediate report to senior management and adult safeguarding." 10:19 10:19

So, Mr. McKervey, having heard me read that into the record are you content to adopt that statement then as part of your evidence to the Inquiry? 10:19

A. Yes.

4 Q. If we go back to paragraph 7 to begin with please?

A. Yes.

5 Q. And picking up on what you tell us about the internal assurance document that you make reference to? 10:20

A. Yes.

6 Q. Regarding complaints and reporting mechanisms. In your role what would your Oresponsibility have been around -- and you were 8B I think at this particular time; is that right? 10:20

A. I was in my post as service manager at the time.

7 Q. Yes?

A. So this was something that was nursing led, it was led

by Brendan Creaney, Director of Nursing, so I didn't really have any -- this was an assurance that was required by nursing.

8 Q. Yes?

A. I didn't have any direct involvement in it at all. 10:20

9 Q. But would you and other 8Bs have had a role in distributing it, in other words cascading it?

A. No, it would have been, to be fair it would have been 8C divisional nurse who was responsible. 8Bs were sort of more operational management, so it was nursing led. 10:21

10 Q. Okay and how would its content have been broken down, if you're able to help us with this, broken down and sort of made easy and quick for nurses on the ground to understand?

A. Right, okay, so I never seen the document. I just left 10:21 at that point so I didn't really see the capacity of the document or any outcome because I had left at that point.

11 Q. All right, thank you. Okay, and then just moving on then to when you first come to work in Muckamore. Can 10:21 you tell us who it was you would have considered to be your, if you know the name, I should have indicated to you, you have a cipher list which I hope you are aware of?

A. Yes. 10:21

12 Q. If you know the name of the person and if there is such a person --

A. There is.

13 Q. But can you tell us who your direct report would have

been, in other words who you would have considered your line manager so to speak?

A. That would have been -- her name is not on that actually. I think her name is mentioned here, Jan McGall.

14 Q. She doesn't have a cipher, that's fine.

A. Yeah.

15 Q. She would have been the person to whom you would have reported then?

A. Yes. 10:22

16 Q. You did not have a specific job title?

A. No.

17 Q. Can you give us a description or something approximating to it?

A. Okay, so myself and Jan McGall were sort of received in Muckamore in and around the same time as there was a change of management at that time. Now Jan, I knew Jan previously, she was an 8B Operations Manager in Belfast Trust Mental Health Services so I would have been responding to her directly. So I was classed as a sort of like a peripatetic assistant service manager which was somebody who, as I have tried to explain in the document, was -- from my experience people would have come to me for advice and support about management systems, managing off duties and the systems they had to monitor staffing levels, et cetera. But I would have met with Jan fairly regularly. 10:22 10:22 10:23

18 Q. And you're very clear in your statement that you reached out, you initiated the contact?

A. I did.

19 Q. Saying 'is there any way I can help'?

A. Yeah.

20 Q. Of course, you made that offer against the backdrop of what you saw developing in the media? 10:23

A. Yeah.

21 Q. Did you know more specifically whether there was an actual need for somebody with your experience and expertise?

A. No, no. Well, I suppose when I got there, yes, I definitely felt -- I mean, I suppose I got the impression that I was quite helpful to people. 10:23

22 Q. Yes?

A. Because you got the feeling that some systems were working well and some systems weren't working so well, particularly in relation to managing sort of like initially when I went there they were reporting, they were doing staffing numbers on a daily basis, but they were just doing numbers. So they would have, for instance, Cranfield 1, they would have had 12 staff in the morning, 12 in the afternoon and maybe seven or eight at night. But what it didn't do, it didn't differentiate between who was trained, who was untrained, skill mix, learning disability nurses or mental health nurses, so that was the sort of thing I would have been looking at, just to see if there was something that could be presented to the senior management team we could change this and maybe this would give us a better overview or an idea of what the 10:23 10:24 10:24

current staffing levels were.

23 Q. Okay. In that role, the peripatetic assistant service manager, is that something that you would have considered to be patient-facing?

A. No, I wouldn't have been associated with any patients really at all. 10:24

24 Q. Yes?

A. I wasn't a named nurse for any patients or had no direct responsibility for any patients.

25 Q. In a few minutes we'll come back to what you said about being on the wards and so forth. All right, and in terms of the practical day-to-day so business of how you would have interacted and communicated your thoughts and recommendations about the gaps that you were seeing? 10:24 10:25

A. Yeah.

26 Q. My words, not yours in fairness, but in terms of the issues you were identifying, how would you have gone about that?

A. So I would have been based in the administration building in Muckamore Abbey. I would have met periodically the senior management team who were in the administration side. I would have been involved in a Teams call, the safety brief call every morning which went through a variety of what would have happened the previous 24 hours and then you would look and you would plan for the next 24 hours in relation to staff complement, sort of looking after the pager system, et cetera, and reporting of any incidents et cetera. 10:25 10:25

27 Q. When you entered the hospital initially, you described there being no induction, for you anyway?

A. Yeah.

28 Q. Was there any other discussion or briefing given to you in terms of protocols and processes particular to Muckamore? 10:26

A. Well I would have been, I would have been aware of all the protocols because they were similar to mental health so I would have known things about observations policies and I would have known -- I actually got a tour of the wards. I can recall being introduced and walked around the day treatment services which I was quite impressed with, to be honest. When I say I got no induction, I was brought around the system, I would have been introduced to people. I would have known a few people from the mental health background but I would have had an induction from the point of view of an awareness of all the wards. 10:26 10:26

29 Q. Yes?

A. And who was the managers of each ward, et cetera. 10:27

30 Q. But of course you were coming from a mental health background?

A. Yeah.

31 Q. Was there anything, therefore, learning disability specific, in other words specific to the environment at Muckamore? 10:27

A. No, I mean other than, I mean a sort of general awareness of the patients, but I wouldn't have had a detailed overview of the patients.

CHAIRPERSON: Just so that I'm clear, would you have expected one or not really because you weren't going t be --

A. Not really, no. I felt comfortable enough being in that environment, I wasn't anxious about it. I felt that my past experience would have been used in my gaining awareness of the environment quite quickly. 10:27

32 Q. MR. MCEVOY: I mean on that score, as for others, elsewhere in your statement you are clear about the delineation between mental health nurses and learning disability nurses and the specific attributes that one looks for in a learning disability nurse? 10:27

A. Yes.

33 Q. Is there anything more you would say about that?

A. Well, you see, I think the Trust were caught between a rock and a hard place to say from the point of view the availability of learning disability nurses were becoming more and more depleted with the unfolding investigation and police Inquiry, et cetera. I think the Trust did the right thing from the point of view that they had built this relationship up with an agency, the agency had confirmed and said they were going to try and provide 45 whole time equivalents to cover deficits, which they seemed to be quite successful in doing. However, there is definitely a difference between mental health nurses and learning disability nurses. They do different training. So, I think, if I was to reflect and say could they have put 45 general nurses in there, I don't think that would 10:28 10:28 10:28

have been --I think the Trust tried to do the best that they possibly could given the circumstances.

34 Q. In paragraph 11 you say the staff appear to be traumatised. Do you know whether there was any form of support afforded to the staff? 10:29

A. Yeah, yeah. To be honest there was, I could see that there was good support from the point of view I was aware that there was counsellors on site and that the staff had been made aware of these, I don't know -- I wouldn't have known how often the counsellors would have been contacted. But, I think, you know, that availability was there for staff whenever they needed to use it, they just rang up and then there was a staff care service that was separate to that, that the Trust managed and the staff knew they could ring also. 10:29

35 Q. And do you know whether staff, in fact, made use of those?

A. Well I would have personally given them, some staff, the numbers if they had have been a bit upset or distressed, I would have sourced the number for them and given to them to contact. Whether they would have contacted or not, it would have been confidential and I wouldn't have been made aware. 10:30

36 Q. DR. MAXWELL: Can I ask a little bit more about that, because obviously there is support for their individual stress, but you talk about the changing environment, large number of new staff coming from England? 10:30

A. Yes.

37 Q. DR. MAXWELL: Some from ethnic minority backgrounds?

A. Yes.

38 Q. DR. MAXWELL: We know that there are challenges in forming teams. What work was done to ensure that team work was effective when so much change was happening in a very difficult context? 10:30

A. Yeah, I mean, I wasn't responsible for having anything to do with agency nurses coming in, but I think there was, yes, there was good enough integration at times. However, I think there was, this would have been between the agency and the Trust, a decision making 10:31 about induction et cetera, I don't know what induction --

39 Q. DR. MAXWELL: I'm not talking about induction. I am talking about proactive measures. So you were brought in as a professional lead manager? 10:31

A. Yeah.

40 Q. DR. MAXWELL: Not to do clinical work but to bring your nursing leadership skills to management and I recognise the responsibility was probably with Jan McGall as a service manager? 10:31

A. Yes.

41 Q. DR. MAXWELL: But what did the local management do to establish and maintain good team working?

A. So, the managers, the other ASMs who were in the service would have been in the wards. I can recall 10:31 having a meeting with the agency staff on one occasion, all the staff just to see how they were getting on and how they felt things were going and that's where I said they were raising difficulties about the PARIS system,

about integration from the point of view of coming to Northern Ireland, et cetera, and being employed in their role. I'm not saying it was all plain sailing but it was, we tried our best just from the point of view of meeting with them and any particular issues that they had, we made sure that we tried to address them as much as possible. I think from one of the points that we were getting raised in the meeting, I had only one meeting with them, myself and another SM, there was an idea that the patients were seeing the agency staff as being different. So there was a proposal to see if they could get the agency staff into Belfast Trust uniforms which would sort of mean that for the staff on the wards, plus for the patients, that there was a greater awareness, there weren't strange people coming into the wards. 10:32 10:32 10:33

42 Q. DR. MAXWELL: So there was support for the agency staff but what support was offered to the substantive Muckamore staff who had this cloud of the allegations hanging over them, didn't know if they were going to be interviewed in relation to the allegations? 10:33

A. So staff on the wards would have had supervision.

43 Q. DR. MAXWELL: Clinical supervision?

A. Clinical supervision.

44 Q. DR. MAXWELL: And who was providing that? 10:33

A. That would have been charge nurses, ward sisters who would have been providing it to the staff on the wards.

45 Q. DR. MAXWELL: And who was giving clinical supervision to the ward sisters?

A. Well the ASMs, the assistant service managers.

46 Q. DR. MAXWELL: So were you involved in doing clinical supervision?

A. Yeah.

47 Q. DR. MAXWELL: Did you have a named groups of staff you were the clinical supervisor for? 10:33

A. Did I have personally? No, I hadn't, but the other assistant services managers had.

48 Q. DR. MAXWELL: So you weren't providing supervision?

A. I provided some supervision to some of the staff. I can remember one particular ward manager, she was a Band 7, I would have seen her I think on a monthly basis. 10:34

49 Q. DR. MAXWELL: A monthly basis, thank you.

50 Q. CHAIRPERSON: Just while we are on the topic of teams, just so I understand, there was obviously -- there appears to have been a lot of movement of staff at the time that you were there, there were agency staff coming in? 10:34

A. Yeah. 10:34

51 Q. CHAIRPERSON: Mixed with permanent staff. Was there also a lot of movement as between the wards or was there an attempt that you could see to ensure that teams on wards remained cohesive?

A. Probably -- I wasn't aware of any sort of team building days as such which probably I would have had experience of in the past. So the teams, I mean, there would have been a ward managers' meeting every Friday morning which I didn't attend. That would have been an attempt 10:34

to sort of get an overview of how teams were doing. I wouldn't have been part of that discussion, but I know there would have been minutes taken and every, I think it was probably every week that meeting happened on a Friday morning.

CHAIRPERSON: Okay, thank you.

52 Q. MR. MCEVOY: Perhaps picking up on that going onto the next paragraph, paragraph 12, having described the particular attributes of learning disability nurses and so on that we've touched on, you say about half way down the paragraph:

"My impressions from the outset at Muckamore were that the multidisciplinary teams and the nursing teams seem to be very fragmented. "

Can you tell us how you formed that impression?

A. Maybe fragmented isn't the right word. So I suppose what I would try to say is there were seven wards that had to be accounted for, multidisciplinary team-wise, and to have a proper multidisciplinary team would you have required a speech and language therapist, you would have required a behaviour support nurse, a psychiatrist, a learning disability consultant, social work and occupational therapist and of course a learning disability nurse, which numbers were being sort of depleted. I'm not -- I mean I don't know for certain but I would have been under the impression that those numbers of people in that ward to decide on

behaviour support plans were not as evident as they could have been. I think there may have been some problems and obviously Psychology would have been involved also. I don't think there was a full membership of the multidisciplinary team in each ward. I think there was three consultants for all seven wards as far as I can recollect.

53 Q. So by being fragmented, what do you mean?

A. I don't mean sort of fragmented, I suppose what I'm trying to say is that there wasn't full membership of a multidisciplinary team on each ward. 10:37

54 Q. And were there any wards in particular which seemed to suffer more than others in terms of a reduced cohort of membership?

A. I think on recollection, I think Erne possibly could have been difficult to get that multidisciplinary team. 10:37

55 Q. Any others?

A. I can't really -- I'm not sure exactly to be honest.

56 Q. Erne is the one that stands out?

A. Erne is the one that stands out. 10:37

57 Q. The services you then say in the next sentence that become very preoccupied by governance and paperwork, which was understandable given the circumstances?

A. Yeah.

58 Q. Can you tell us what you think from your recollection drove that? 10:37

A. I think, there would have been a sort of, I talked about the live governance meeting which was minuted, I wasn't used to that sort of level of input from teams

and levels of reviews of incidents and complaints every week. That seemed to be quite a substantive document and it took probably about an hour and a half, I'm sure it took a lot longer to minute it and that sort of happened on a regular basis. I think really on the basis of ASG referrals, there seemed to be a lot of ASG referrals. And even from my personal experience of completing form 2s, form 2s seemed to be something that was completed very readily. In my previous post we would have completed a form 2 to RQIA if there had have been a death, a suicide, a serious assault against a patient, an assault against a patient or a staff member. So the threshold seemed to be a lot lower. 10:38 10:38

59 Q. Are you saying then, are you telling the Inquiry in your opinion -- 10:39

A. In my opinion.

60 Q. There was an over reporting?

A. Well, no, I think it was a consequence of the media reports, the news, the investigations. I thought in my opinion that there was a difference from what I used to see previously. 10:39

61 Q. DR. MAXWELL: Could you give an example of the sort of thing that was now being reported that perhaps wouldn't have been in your experience earlier in your career?

A. When I make reference to -- I mean if I'm saying in relation to form 2, it would have been a serious event, for instance. 10:39

62 Q. DR. MAXWELL: I understand but what sort of thing was now being reported on form 2?

A. I think anything in relation to staff and patient was being --

63 Q. DR. MAXWELL: So could you give an example?

A. Yes, that one that I just gave in this document, the water pouring of the patient. That normally wouldn't have met the threshold for RQIA involvement. 10:40

DR. MAXWELL: Right, thank you.

64 Q. CHAIRPERSON: But you also say that you were taken aback by levels of assaults and incidents within the hospital? 10:40

A. Yeah.

65 Q. CHAIRPERSON: Are you referring to patient on patient or patient on staff?

A. I am talking about patient on patient and patient against staff. I mean, I suppose what I'm saying is in my mental health background and my previous post I wouldn't have seen as many incidents. I had nothing to gauge this against. I hadn't worked in learning disability for that type of -- 10:40

CHAIRPERSON: You had no measure --

A. I had no measure. It was a feeling that I had. It seemed to be a lot of cases, probably 20 a week, and I was only just ascertaining that through the live governance meetings. If you see the minutes it would indicate those. So it was things like hair pulling, head banging and self-injurious behaviour. 10:40

66 Q. MR. MCEVOY: We can gauge from what you have just said that nothing had prepared you for that, you knew something about what was going on in Muckamore from the

media?

A. Yeah, no.

67 Q. And obviously then you put your hand up to go and work there, but nobody had given you an indication then of other assaults that were going on in the hospital between patients, patients and staff? 10:41

A. No, no.

68 Q. DR. MAXWELL: Can I ask, you were taken aback, did you say to anybody --

A. I would have said to the managers, look, I think there is a lot of incidents here. 10:41

69 Q. DR. MAXWELL: What was their response?

A. Well I think looking at it through live governance and see if there was anything that could have been done differently or managed differently. 10:41

70 Q. DR. MAXWELL: I suppose what I'm asking is, did they say this is a normal level for learning disability services or, yes, we agree this seems higher than we'd expect for learning disability?

A. That would have been the governance department would have been looking at trends and analysis of incidents and stuff like that. There was a produced document every couple of weeks, every month in relation to -- as I say I was only there two days a week, I wouldn't have known the inner complexities of dealing with -- 10:42

71 Q. DR. MAXWELL: Okay, but there was a written document so if the Inquiry wished, we could ask for The Trust's -- for the trend analyses?

A. Yes.

72 Q. DR. MAXWELL: We can see for ourselves whether it was going up or down or staying static?
A. Yes.
DR. MAXWELL: Okay, thanks.
73 Q. MR. MCEVOY: On that theme, you said towards the end of the paragraph: 10:42

"There was a very high reliance on documentation and minute taking."

10:42

Which is something you have also touched on.

"A large volume of paperwork with incidents happening most days, it was very difficult for the staff to manage and it was having an impact on staff morale." 10:42

First of all was that difficulty and impact felt by staff at a particular level or at various levels?
A. I think various levels to be honest, and I think the ASMs, some of the ASMs found it quite difficult. 10:43
74 Q. What about down the ranks, the bands, would you have had an awareness of how more junior or less senior nurses or nurse managers would have found it?
A. Purely just through conversations with them, just that they were finding the whole process very difficult. 10:43
75 Q. A general struggle?
A. Yes.
76 Q. Did you make that point to anyone in authority in the hospital about the your perception of the impact on

staff morale?

A. Yeah, we would have had discussions in our senior management team, I think they would have been aware.

77 Q. Would you have conveyed that concern?

A. Yeah. 10:43

78 Q. And presumably, given that we are talking about minutes and a plethora of them, there would be minutes that would indicate that being discussed?

A. I'm sure there would be minutes about it.

79 Q. Okay. In terms of the governance meeting, can you give us an overall picture, you may have done this already but just so we have it clearly, of who all would have been, either in terms of grade or band, who would have been in attendance at the governance meeting? 10:43

A. Okay, so, as I say, I didn't attend many of them, I got the minutes. From my recollection there would have been the clinical director, there would have been adult safeguarding team, there would have been Band 7s on the wards, and the divisional social worker and people, as I say, from adult safeguarding would have been at that meeting, the Teams, the live governance meeting. 10:44 10:44

80 Q. And in terms of the issues and incidents that were discussed at them, do you know how then those were escalated or if they were escalated?

A. So my understanding is that they would have been carried forward to the following week, anything that wasn't resolved at that meeting or discussed would have been carried forward to the following week. 10:45

81 Q. So it was a running series of actions then?

A. Yes, yeah.

82 Q. Okay. You then identified in terms of the systems and issues, looking at paragraph 18 of your statement, wanting to implement better systems and one of those was the emergency response system? 10:45

A. Yes.

83 Q. Were pager systems used in other services throughout the Trust?

A. Yeah, my own service when I managed them, each ward had an independent incident response system, primarily to 10:45 provide assistance if it is required for sort of like if there was a fire or if there was an emergency from a cardiac arrest point of view, or if there was an issue of aggression or violence on the ward.

84 Q. And you say that the pager system then at Muckamore 10:46 you've discovered wasn't working properly. Was the technology around the pager system, the equipment and so on, was it as up-to-date as you would have had knowledge from other --

A. It was a similar type of system. It was an alarm 10:46 system where a staff member pulls a pin and sends a message to a designated area which notifies pagers and notifies the staff where to go to, wherever the incident is happening. Yes, so all systems, all hospitals tended to work that way. 10:46

85 Q. Yeah?

A. And as I say, whenever I went to, whenever it was raised with me there was something wrong with an antennae, a situation which wasn't -- meant that

periodically the pagers wouldn't work properly. So that's why I took to do with trying to get that --

86 Q. Do you know were they used, the pager system, you say it wasn't working properly, was it used to the extent that you would have expected based on your experience in other facilities? 10:47

A. Yes, it was used, it was used in a similar way.

87 Q. And do you know when you became aware of the system with the antennae, do you know how long that issue had been prevailing for? 10:47

A. It was reported to me by another ASM that she had been trying to deal with it and she couldn't get it sorted, so then I looked to try and deal with -- I got in contact with estates just to see, and I think there may be some money had to be released to put another antennae up to make the thing work properly. 10:47

88 Q. So again, any idea how long that had been a problem for?

A. Probably, maybe about six months I think.

89 Q. Okay, when you went about trying to put those steps in place and, as you say, getting the money to fix it, was there any resistance or any difficulty securing that? 10:48

A. No, none whatsoever, no.

90 Q. Any other practical improvements like that, that you identified and attempted to rectify? It's not a trick question by the way, just in case there is anything along that line? 10:48

A. That was one of my concerns because that sort of system, I was very au fait with and I know I had

implemented such systems at Knockbracken Health Care Park, Mater Hospital and in Windsor House so I was fairly au fait.

91 Q. Something you were alive to?

A. I was au fait with this. In fact, I would have drawn up sort of protocols in relation to that in the past. 10:48

92 Q. CHAIRPERSON: Can I ask on the point about the pagers, you came in and it took you a little while to resolve it but actually you say you didn't find any resistance in terms of money? 10:49

A. No.

93 Q. CHAIRPERSON: Or actually eventually putting it in place. But could you understand why your intervention was necessary, why hadn't that filtered up before you got there? 10:49

A. Probably, I think really there has to be an awareness about these systems and know how they work. I think really probably was it given enough priority? I'm not sure. But I think there was an issue of people not really understanding why it wasn't working properly. All you would have got was there was something wrong with the system, there is antennae, so you had to sort of persevere. 10:49

94 Q. CHAIRPERSON: And you had to know the system --

A. You had to know the system. And to be fair I don't think the people in Muckamore would have been totally au fait. It was a mixture of me knowing how the system worked and how estates worked to try and pursue that. I mean I don't think any of the senior management team 10:49

would have had any background in relation to that type of system to be honest.

95 Q. CHAIRPERSON: No but it is a bit of a case, it maybe an example of a new broom coming in having different knowledge? 10:50

A. Yes.

96 Q. CHAIRPERSON: And you were able to do things quite quickly?

A. Yes, yes.

CHAIRPERSON: Yes. 10:50

97 Q. MR. MCEVOY: Turning to paragraph 20 at the top of page 8 then, Mr. McKervey, and you tell us something about your experience of recruitment for Muckamore. You sat on a number of panels for bands 3, 6 and 7 respectively, was there any specialism or any 10:50 particular requirement in relation to any of those jobs for Muckamore?

A. Well, there would have been for learning disability staff of that level, 3, 5 and --

98 Q. And they would have been advertised as? 10:51

A. Advertised as learning disability posts.

99 Q. And you say applications for senior positions were hard to recruit into?

A. Yeah, yeah.

100 Q. But presumably it wasn't, the difficulty wasn't just 10:51 confined to senior positions then?

A. Well, band 3s were probably easier to recruit into, but it wasn't band 3s that the service was requiring, it was Band 5s, 6s and Band 7s.

101 Q. DR. MAXWELL: By which you mean registered nurses because of course Band 3s aren't?
A. No.
102 Q. DR. MAXWELL: So it was registered nurses with the learning disability registration? 10:51
A. Registered nurses, yeah.
103 Q. MR. MCEVOY: So the problem remained with registered nurses across the spectrum of seniority essentially?
A. Yes.
104 Q. "...Often no applications, particularly for senior posts. Very few applications for learning disability nurses." 10:51

Do you know whether the Trust took any steps to try and improve interest and if so what steps? 10:52
A. I'm not sure. I had no involvement in that from a recruitment and retention aspect. I mean I was just reporting on what my experience was of recruitment. It seemed quite difficult to get learning disability trained members of staff. 10:52
105 Q. Do you recall it being a topic of discussion with colleagues?
A. I think it was, with colleagues, yeah. I mean I suppose the Trusts were putting rolling adverts out and they weren't getting the response that they would have liked or expected for jobs. 10:52
106 Q. DR. MAXWELL: Did you ever know whether they considered any incentives? Sometimes in hard to recruit areas, Trusts will give incentives, whether that's financial

or otherwise?

A. There was, there was. I'm not exactly sure, but I think there was 12% uplift in wages for staff and I think they were really trying hard, positive image, et cetera, but just unfortunately people weren't applying for the jobs.

107 Q. MR. MCEVOY: Now, turning to paragraph 23 then, coming back, a bit earlier on in your evidence I asked you about whether or not you would have considered yourself in a patient-facing role and you were pretty clear it wasn't? 10:53

A. No.

108 Q. But you say at the top of the paragraph 23 you're on the wards one or two times a day and "other than the incident that was reported to me", which is the one we've talked about, the hair washing incident, if we put it that way, "I did not see any abuse of patients, poor care or anything I was uncomfortable with." In what capacity would you have been on the wards once or twice a day? 10:53

A. I would have been in just to have a chat with staff, speak to the managers, general conversations. Towards the end I was doing my financial audits, patients' property, so that would have been in meeting with staff, I would have met the other ASMs to chat about staffing levels and numbers. 10:54

109 Q. Would those staff have known, the ward staff have known you were coming?

A. No, it was ad hoc.

110 Q. You could have been down at 10 o'clock, 1 o'clock?
A. Yes, I never had any specific same time every day, I would have been in at various times of the day.
111 Q. Yes. Was there, in relation to each of the wards that you went to, was there any sense of a different practice or culture? 10:54
A. No, I didn't get, no, everybody seemed to be, as I say, operating the same way from the point of view of the regular managers' meetings and everybody was adhering to the policies and procedures that were in place. 10:54
112 Q. Okay. In terms then, what you tell us about the pods to which you make reference at paragraph 25, some patients you tell us were managed in a pod environment.

"This would have been to protect them from potential aggression from other patients." 10:55

I suppose first things first, what would you have understood the pod to entail?
A. The pod, it was like an individual area for the patient to sleep and live and manage. It was something that developed -- from my understanding it was always staffed by, there was always staff in the pod with the patient. So it was a way of sort of minimising any other sort of -- because there would have been occasional interaction and aggression between patients so that was a way of minimising that. I wouldn't have been involved in any decision making in relation to that set up. 10:55 10:55

113 Q. Of course?
A. But I was aware of their existence.
114 Q. Did you ever see inside one yourself?
A. No, I didn't, no.
115 Q. You tell us that a patient who had a pod could leave the pod when required? 10:56
A. Yeah.
116 Q. So in terms of, what sort of requirements would have --
A. The patient would probably leave to go to day services sometimes. 10:56
117 Q. So they couldn't leave therefore as they wished, it was more --
A. I think they could leave if they wished.
118 Q. CHAIRPERSON: Can I ask if you have direct knowledge of this because we have heard a bit of evidence about the pods? 10:56
A. Yes.
119 Q. CHAIRPERSON: So I just want to know what your basis is?
A. As I say, my knowledge of it is limited to be honest, there was an awareness about it. I didn't know the actual procedures and policies in relation to the management of them. 10:56
CHAIRPERSON: No, that's fine, thank you.
120 Q. MR. MCEVOY: Well, I mean if you are unable to answer this of course please just say, but do you know whether there was an understanding about how long a patient would be in a pod for, broadly? 10:56
A. I don't know that answer.

121 Q. No. Okay, in terms then of paragraph 26 and what you touched on about finance audits. Can you recall who it was who tasked you with conducting the finance audits?

A. Was it tasked to me?

122 Q. Yes? 10:57

A. Yes, I think RQIA had been in and had done a review of the financial management and, I mean, they were seeing some discrepancies in the audits themselves. So I think, I mean I was tasked with taking these on as a person who could have focus on it and trying to, and 10:57 manage and look to see if there was anything, you know, in relation to compliance with the audits.

123 Q. Okay, and in terms of, had you any administrative assistance to help you with that task?

A. Well, yes, there was a person who had been employed as 10:58 a finance officer, which seemed to be a new post, I wasn't aware of that sort of post prior to, in my mental health background, services, there was no -- so there was a finance officer who had been employed. So what they would do, they would send me the list of 10:58 names that I would have to go and do the audits, it was a random selection.

124 Q. Patient names?

A. Yeah, patient names, it was a random selection so I couldn't pick and chose who I was to do an audit on. I 10:58 would have audited a patient's property and their finances.

125 Q. So were these spot checks as such?

A. Yes.

126 Q. Was there a pro forma document?
A. There was a financial protocol which I would have been involved with setting up in my mental health, so there was an idea that myself and another person from learning disability try and devise a policy in relation to the finance. 10:59
127 Q. Okay and the policy that you're describing, was that unique to Muckamore then based on your experience?
A. It was the same policy for mental health was used in learning disability. 10:59
128 Q. So it was the same one that you would have used in pre-retirement so to speak?
A. In mental health, yes.
129 Q. Do you know if that policy had been revised? I appreciate we don't have it in front of us but do you know whether it had been revised in the time since your retirement? 10:59
A. I think it was revised. I can't establish exactly when.
130 Q. Yes? 10:59
A. Maybe 2018, '19, I'm not sure.
131 Q. Were staff familiar, were staff on the ground and on the ward familiar with the policy?
A. Yeah, they were quite aware of the policy. My role was to go in and check on the property and the patients' finances. It's quite, it is a system that's quite difficult from the point of view -- to me it's more problematic in learning disability because of the capacity issues and having -- 10:59

132 Q. Yes?
A. Having to store money. To me it's a bit old fashioned from the point of view you have to keep money in a thing called a Bisley cabinet.
133 Q. Old fashion, locking... 11:00
A. An old fashioned drawer system where you lock it and keep it open. I am thinking really, I mean in mental health it wasn't particularly a problem but now that I have experienced it in learning disability I can understand how it is very hard to keep on top of all 11:00 the documentation. For instance, you go into a ward there was a lot of money, like coins that you have to go and count individually to make sure that the balances tallied. And if you've got 20 patients, that's quite a lot to do from a checks and balances 11:00 point of view twice a day, which is what is expected of the policy. So I think really if there is anything.
134 Q. Yes?
A. So I think really in mental health that has sort of got a bit easier because most patients had bank cards. 11:01
135 Q. Yes?
A. And my experience in previous years was that most institutions had banks. So what was happening was the banks were actually retracting and not available. So, for instance, if you had a lot of money in a particular 11:01 ward, to try and get it back into the bank and exchange it was quite difficult, so that's just my awareness of it and how I find things changing.
136 Q. On that score then, do you feel that the policies and

protocols around patient finances here were, and I know it is a broad sweeping question, but were they fit for purpose given the challenges that learning disability nursing staff had to contend with?

A. Yes, I think they were fit for purpose but they were always open to sort of, you know, if somebody didn't do a signature, for instance, that was the policy not in effect for instance. So you would come across two trained nurses, one of them might have signed it and the other one hadn't signed it. But at the end of the day I found that the balances were right but it's just the administrative part of it which was quite difficult to maintain. 11:01 11:02

137 Q. And I suppose in one end of the spectrum you might have that sort of a slip up where there is an oversight in terms of counter signature? 11:02

A. Yes.

138 Q. DR. MAXWELL: Can I ask, this twice a day checking, was that done by registered nurses?

A. Yes. 11:02

DR. MAXWELL: And you seem to suggest it is very labour intensive?

A. It is, if you've got 20 patients in a unit, it is quite --

DR. MAXWELL: That's a large portion of the day the registered nurse isn't available to be with the patient? 11:02

A. Yeah, yeah. I mean, it is just my experience of it. Administrative-wise I think it's belt and braces but it

is --

139 Q. DR. MAXWELL: Inefficient?

A. Yes.

140 Q. CHAIRPERSON: Can I just ask in mental health, I must admit until I came across this, I presumed that an electronic system would be used, that each patient would have a card? 11:03

A. In mental health a lot of patients, most of the patients have got capacity so they have their own cards. 11:03

141 Q. CHAIRPERSON: I see, it's capacity.

A. So then you don't have to have the reliance on documentation et cetera.

142 Q. CHAIRPERSON: No, quite?

A. If they have got their own cards they can go to a bank. I'm sure there could be some sort of system similar to that in learning disability, I don't know, in this age of technology, it seems to be coins and paper notes. It is just an added burden on hospital staff to maintain it and it always comes up in reviews of RQIA that something hasn't been checked or the balance isn't right. I just think there could be a better way of managing the system. 11:03 11:03

CHAIRPERSON: I imagine you might be right.

143 Q. MR. MCEVOY: I was just going to ask, on one end of spectrum you might have a simple administrative oversight, failure to countersign or something like that? 11:03

A. Failure to countersign, the RQIA would come in and say

this hasn't been signed.

144 Q. At the other end of the spectrum, the Inquiry has heard some evidence about this there is scope for abuse, particularly on a sort of situation where there is cash around a ward? 11:04

A. I never like having -- I never liked having cash on wards because, you know, all it takes is a cabinet not to be locked properly or, do you know what I mean. And then you've got large amounts of, I mean, it's not the staff's fault, they would get money out to maybe go and 11:04 do a shopping trip, then the shopping trip may have been cancelled so that money would sit in the Bisley until there was an available opportunity for the bank to open to get the money put back in again.

145 Q. Whose responsibility would it have been then to ensure 11:04 the cash was taken out of that drawer?

A. The nurse in charge or the charge nurse or the ward sister. But was just it might be on a Friday evening and the bank wouldn't be open maybe until Tuesday.

146 Q. The cash would be -- 11:04

A. The cash would be sitting in the drawer for that length of time and they would have to check it.

147 Q. Did you ever notice any shortcomings around dockets, receipt dockets for money?

A. No, receipts would have been provided. There would 11:05 have been the odd occasion when a receipt may have been lost, they could have tried to get that and the charge nurse or ward sister would have had to countersign anything that was bought, but again it's all down to

having receipts and staple receipts to bits of paper and that's your way of managing.

148 Q. Did you ever notice any situations where one patient's finances or money were confused with another's?

A. No, I didn't come across that, now. 11:05

149 Q. All right, okay. Just concluding then in terms of what's going on at the minute, obviously we appreciate the Inquiry's terms of reference end in 2021 but just in terms of what is going on at the moment, there is still a process of review of CCTV? 11:06

A. Yeah.

150 Q. It's not real-time, as you say, but there is a system in place where what is happening on CCTV is then examined by a team of staff?

A. Yes, there is 10 staff, all ex -- probably retired 11:06 staff who are from a variety of backgrounds, social work, occupational therapists and nursing.

151 Q. As a nurse with very considerable years experience, what do you feel about that?

A. I find it unusual that the Trust have to have that 11:06 assurance of doing this. I haven't come across that before, because we hadn't got CCTV in the hospital wards, but I can understand why the Trust are doing it from an assurance point of view. It was very different to me, you know, that this was being relied on to sort 11:06 of retrospectively look at things. But it is, as it is at the minute, and that is one of the assurances that the Trust seem to think that it is a good way of reviewing things.

152 Q. You might not know the pounds, shillings and pennies answer to this, but presumably it is an expensive exercise?

A. From an equipment point of view or from an employment of staff? 11:07

153 Q. A whole system process in terms of equipment and staff?

A. It would be quite an expensive, I mean they had to get an extra data requirement because nothing, in Muckamore nothing is destroyed in relation to CCTV footage. So there is that requirement and then there is obviously 11:07 paying people to do this process of reviewing.

154 Q. And is this a project with an end date or is it due to continue?

A. All I know now is probably -- I think from my last, I haven't been there for at least a month I think but 11:07 they are about three weeks behind reviewing. Probably if the place were to close down I would imagine.

155 Q. Of course?

A. I don't know, nobody is indicating to us that it is going to stop at any time. 11:08

156 Q. Mr McKervey, those are my questions for you. Maybe the Panel have some more questions for you.

MR. MCKERVEY QUESTIONED BY DR MAXWELL: 11:08

157 Q. DR. MAXWELL: I have got two questions. The first relates to the incident in paragraph 21 of the agency nurse who was enthusiastically pouring water over a patient's head, so this was an agency nurse, not a bank

nurse?

A. No, agency.

158 Q. Was this from an agency in England that was supplying...

A. Yes. 11:08

159 Q. So processes were followed within Northern Ireland of referring to the RQIA and presumably to the SPPG or whoever it was at the time?

A. Yes, yes.

160 Q. Was the agency notified? 11:08

A. Yes, they were.

161 Q. What was the process for notifying the agency because of course if this person is from England, none of the safeguarding processes in Northern Ireland will apply?

A. I'm not sure about that now. I do know that the 11:09 person, the referral was also made to the bank in Belfast Trust.

162 Q. Not the agency?

A. And the agency were also notified.

163 Q. Who notified the agency, was it the bank -- 11:09

A. It would have been the bank and the Trust.

164 Q. But the bank is part the Trust isn't it?

A. Yes.

165 Q. So nobody at Muckamore was talking directly to the agency? 11:09

A. I'm not sure about this individual case, whether that happened or not. I think it did from what I can gather.

166 Q. Okay because there is a risk that this person then goes

home to England where they are not subject to anything?

A. Absolutely, yes, they could do.

167 Q. Thanks. The other thing I wanted to ask you about, you talk in paragraph 18 about wanting to improve systems and you answered one of my questions to say you were providing clinical supervision to one of the ward managers. I wonder if anybody, if you ever had any discussion about the conditions that meant it was difficult for staff to follow best practice. So were staff saying actually we know what best practice is supposed to be but actually we can't adhere to that because we don't have enough staff or because this patient's behaviour is particularly distressed and they can't comply with the best practice for manual handling? 11:09 11:10 11:10

A. Yeah, I think I can understand your question. I think it was difficult for them to manage some of the behaviours and I'm not sure whether the expertise was there in relation to making sure that they could get a handle on some of the behaviours that were happening. I think really from the point of view it was difficult for them. I think if I can reflect back to mental health, there would have been, you know, teams sometimes became exasperated at times and, from my point of view, I would have tried to make sure that there was internal rotation, increased supervision and I think -- and an acknowledgment that teams do find things quite stressful and difficult and there is almost a difficulty in them saying we don't know what 11:10 11:11

to do here, we need help. And I think if I was to reflect on Muckamore, I think that would have been the occasion at times because in mental health we would have made referrals to Carstairs, we would have made referrals to the Shannon Clinic Regional Forensic Service. I didn't think that that was the availability of Muckamore. I think they felt that they had to deal with whatever they had to deal with and there wasn't that opportunity to -- so I think teams probably become a bit jaded and tired over a period of time of dealing with the same behaviours with not knowing how to resolve them. 11:11 11:12

168 Q. So we did hear from a retired behavioural nurse therapist from Muckamore who said that some patients with particularly distressed behaviours who were on level four observations, that's very intense work? 11:12

A. Yes, it is.

169 Q. And people should be given, staff should be given a break after two hours?

A. Yes, that's right. 11:12

170 Q. Was that happening at Muckamore?

A. I think, no it was happening, but I think some of the behaviours were very, very difficult, I have to say. You know, and sometimes the policies didn't fit around those particular behaviours. For instance, if somebody, I mean some learning disability patients would pick that pen up for instance and try to swallow it. That person may be on observations. But the special observation or close observation policy would 11:12

only have really two levels, it would be within eyesight or general observations. So if you were a nurse you were would have to be very, very aware of what that patient could potentially do and you would have to stop them doing that. Sometimes the behaviours didn't really sit within the parameters of the policies that they were aware of. So I mean, that was something that I picked up on that was quite difficult for people to manage situations.

11:13

171 Q. And just a final question about that, a lot of the staff who were doing this close observation were healthcare assistants?

11:13

A. That's right.

172 Q. And they hadn't had a professional education?

A. No, no and that was the policy. It was meant to be under the direction of a supervised, registered nurse.

11:13

173 Q. No, I understand that but it's intense and demanding work?

A. It is.

174 Q. Do you think the healthcare assistants were given sufficient education and preparation to manage these very complex behaviours?

11:13

A. I think, well they were generally Band 3 nurses. Well you see the caveat of that was that it was usually under the direction of the supervised nurses. I have no doubt that they found it quite difficult.

11:14

175 Q. But do you think they were given enough education and preparation, given that there are no standards for what education Band 3s have?

A. On reflection I think there could have been a greater awareness or clarity on what and how to manage these policies and procedures in relation to learning disability patients.

176 Q. Okay, thank you very much. 11:14

MR. MCKERVEY QUESTIONED BY THE CHAIRPERSON:

177 Q. CHAIRPERSON: And I think you tell us a lot of these staff came over from England, a lot of the agency staff? 11:14

A. Yes, they did, yes.

178 Q. Came from England, and even using agency staff and a different jurisdiction, they don't seem to have been able to find sufficient LD trained staff? 11:15

A. No, no. I mean if you think about learning disability, you think about Muckamore Abbey, that was where the general population of learning disability nurses were, plus the community. But you would have had to all the people, learning disability nurses out of the community into the wards. 11:15

179 Q. To the hospital?

A. And I think they are trying to sort of move people out into the community.

180 Q. Yes. 11:15

A. There just wasn't, compared to England, Scotland and Wales, you would have had a greater pool of learning disability nurses, whereas I think Muckamore hadn't got that capacity.

181 Q. Sure, but even there, it doesn't seem that they were able to source sufficient LD trained nurses?

A. No, no.

182 Q. So there was a problem?

A. That's why they went to this agency contract. 11:15

CHAIRPERSON: Thank you. I've asked all my questions as we've gone along so can I thank you very much, Mr. McKervey, you are our last witness for this year but thank you very much for your statement and for your very balanced and helpful evidence. If you would like 11:16 to go with the secretary to the Inquiry, thank you.

A. Thank you.

THE WITNESS WITHDREW

11:16

CHAIRPERSON: All right, well that concludes the evidence today and I've just got a few words to say at what is effectively the close of the year for the Inquiry. It is perhaps obvious that we had hoped that there would be significantly more witnesses that would 11:16 be called this week, which unfortunately wasn't possible. Some of the statements were lengthy and couldn't be finalised to the witnesses' satisfaction in time. Two of the witnesses that we had hoped to call were taken ill and were unable to sign their 11:17 statements. So, for those reasons we were unable to call more evidence this week, which for obvious reasons I was keen to do.

On a brighter note it is worth reflecting on what the Inquiry has achieved to date. Today is our 72nd day of sitting. We have just heard from our 136th witness. We have completed the patient experience in its entirety. We have finished the evidence in Modules 1 to 5 dealing with the law, legislation and policies around the provision of services to those suffering learning disabilities and we have started to hear from staff at the hospital. 11:17

This section of staff evidence was perhaps always going to be one of the most challenging areas of the Inquiry and I set out many of those complexities and Inquiry's approach to them in my public statement on the 2nd November. I won't repeat here all the issues I set out then but, suffice to say, it is a relatively complex process. Again, I want to encourage potential witnesses to engage proactively with CFR. Anyone with concerns can speak to the Inquiry staff or to Napier Solicitors, who have been appointed to look after staff who do not want to use DLS, the Trust solicitors. Anyone who wishes to can make an appointment with Jaclyn Richardson, the Inquiry secretary, or Lorraine Keown, the Inquiry solicitor, who can both provide further explanation about the process of engaging with the Inquiry. 11:18

For any staff member coming forward they can have early access to any of the Inquiry's counsellors if that

would provide comfort or reassurance and staff can ask for special measures to assist them such as screening or anonymity, just as patients and relatives did, and any such request for good reason will be carefully considered by me. 11:19

The Inquiry has identified a number of members of staff it wishes to speak to and obtain statements from and most of those have been written to. Some have indicated a ready willingness to give a statement. 11:19 Others have been more circumspect or have sought to avoid doing so.

Let me be blunt about this, so far I have avoided issuing a notice under Section 21 of the Inquiries Act 11:19 requiring a statement to be given. I am still keen to rely on people to volunteer a statement but I recognise that there may be those who simply refuse or others who are reluctant to make a statement because of their own concerns or because of external pressures. For some of 11:20 those a requirement to give evidence by way of Section 21 will be a positive benefit in that it removes the voluntary aspect of making such a statement. I expect witnesses who have been identified by the Inquiry to make a statement to do so and if we do face refusal, 11:20 for whatever reason, I will have to consider the use of Section 21 notices in order to compel the provision of a statement.

We have also slightly streamlined the process. Whereas previously all potential witnesses should have received a pre-statement questionnaire to fill in, that process will now be shortened by CFR, the appointed firm to take witness statements, contacting the witness directly or via their solicitors where known and compiling the necessary information at the first meeting. 11:20

Can I just then deal with the issue of patient document requests. In March of this year we issued 19 patient document requests to the Trust. Those requests were based upon the evidence which the Inquiry had heard from June to December 2022. In some cases specific types of record were called for, in others all of the patient documentation between defined periods as requested. The Trust prepared the documentation in response to those requests but unfortunately their provision to the Inquiry was delayed significantly by a judicial review. The judgment in that judicial review was given last month when the claimant's argument was rejected and the Trust promptly complied with the original request. We are currently in the process of informing those patients in relation to whom records have been provided, either directly or to their next of kin or authorised representatives. 11:21 11:21 11:21 11:22

A further set of patient document requests will issue shortly, I hope before the Christmas break. These

requests will be based upon the evidence heard from patients and their relatives this year. When that material is supplied to the Inquiry, we will alert the relevant patients or appropriate next of kin via their solicitors.

11:22

Let me turn to the plan for next year. We will sit again on the 5th February 2024. We will try to complete the staff evidence in early to mid-March. In March 2024 we hope to hear evidence relating to go Module 6 which will deal, among other things, with the Ennis report and the outcomes and the consequences of that. I expect that evidence to take approximately two weeks.

11:22

11:23

The plan is that from April to May we will hear from the organisations. This time we will focus not upon processes and protocols, but how effectively those worked in practice and what could or should have been done better. Letters will issue at the latest in January next year to alert the organisations from whom we'd like to hear and the topics which we would like to hear about. If things go according to schedule that will give us June to conclude any outstanding evidence.

11:23

11:23

Finally, I want to thank all the Inquiry staff and counsel, our technical and stenographic teams who have worked hard all through the year. I want to thank Cleaver Fulton Rankin Solicitors and our statement

taking team there and I want to thank all Core Participants and their lawyers for their contribution to the Inquiry.

It's a little bit early, but I will wish everybody a Happy Christmas when it finally comes, and we will meet again on the 5th of February next year, thank you very much. 11:24

THE INQUIRY ADJOURNED TO MONDAY 5TH FEBRUARY 2024 11:24