

MUCKAMORE ABBEY HOSPITAL INQUIRY
SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL
ON MONDAY, 13TH NOVEMBER 2023 - DAY 68

68

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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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1 THE INQUIRY RESUMED ON MONDAY, 13TH NOVEMBER 2023 AS
2 FOLLOWS:

3
4 CHAIRPERSON: Good afternoon, thank you. Well, welcome
5 back to everybody. I'm going to make a few comments 13:57
6 just about the session that we're about to start but
7 I'll keep the remarks brief as I'm very conscious of
8 course that we have a witness waiting to give evidence,
9 but I just want to say a few words about our approach
10 to staff evidence which of course is starting this week 13:57
11 and will then continue in December.

12
13 On the 6th of November I issued a statement dealing
14 with how the Inquiry proposed to deal with staff
15 witnesses and statement taking. That was published via 13:58
16 the website, it was quite lengthy and I'm not going to
17 repeat it here. But we will start today to hear
18 evidence from members of staff at MAH. It's obviously
19 an important part of the Inquiry and it's important
20 that we do everything we can to encourage staff to come 13:58
21 forward.

22
23 As I've said repeatedly, we need to hear about good
24 practice at the hospital. I'll carry on, as I said
25 repeatedly we need to hear about good practice at the 13:59
26 hospital as well as poor practice. We have already
27 identified a number of individuals we want to speak to
28 and that process of identifying witnesses will
29 continue.

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we have thought carefully about whether this module of evidence could be streamed via the website in a similar way to how we streamed the evidence in modules 1 to 5 which we heard earlier in the year. I've decided not to do that and to treat this in much the same way as we heard the patient experience evidence. So this evidence will not be streamed live outside the Inquiry centre. There are a number of reasons for that decision but foremost in my mind is the importance of encouraging members of staff to come forward and express themselves freely and, in my view, streaming this evidence live would not necessarily assist in that.

Secondly, I have to be constantly vigilant to ensure that we do nothing to interfere with the criminal investigations and the criminal trials. Live streaming of that type of evidence may attract significant attention and that could have an adverse effect on the criminal trials.

Unless I place further restrictions I will not prevent the press from reporting on the evidence, they have their own rules and standards and they are also conscious, no doubt, of the importance of ensuring that they do not report material in such a way as to offend the rules laid down to protect criminal trials.

1 I have also considered whether we should publish the
2 statements of staff witnesses on the website.
3 Obviously all CPs have those statements in any event.
4 Every public inquiry has to be aware of its
5 responsibilities to be as open and transparent as 14:00
6 possible. This particular public Inquiry faces fairly
7 unique issues, in large part because there are
8 concurrent criminal proceedings. Statements often
9 require redaction and no doubt we will receive
10 applications from either the PSNI or the PPS further to 14:01
11 redact statements beyond just the ciphering of patients
12 and staff names.

13
14 The safest way to proceed and the one that runs least
15 risk in my view is to allow the transcripts to be 14:01
16 published, but not the statements. In that way he can
17 ensure as best we can the publication of potentially
18 prejudicial material is avoided.

19
20 It's for that reason that we will keep to the system 14:01
21 which was used for the patient experience witnesses of
22 reading parts of the statements into the transcript.
23 In my view that meets the public expectation of
24 openness and transparency in relation to the material
25 which will be taken into account by the Panel. 14:01
26

27
28 Counsel will have a discretion as to what to shorten or
29 to precis, but in general terms I would expect anything

1 of significance in a statement to be read into the
2 record.

3
4 We will also continue to take a precautionary approach
5 to the ciphering of staff names in the statements and 14:02
6 evidence as we have to date.

7
8 Further, counsel will adopt a precautionary approach to
9 referring to staff names generally where the use of
10 names in public isn't necessary for the Inquiry's 14:02
11 purpose.

12
13 This is our first week of staff evidence and it is to
14 some extent a test run. We'll be hearing evidence in
15 various formats. Some witnesses will simply appear and 14:02
16 give evidence from the witness table as this
17 afternoon's witness is going to do. Others may be
18 screened from view. One witness will give evidence
19 remotely. Another may be read. That is a
20 demonstration of what I've said repeatedly at 14:02
21 engagement sessions; the Inquiry will do what it can to
22 ensure that witnesses can give their evidence in a way
23 which is, as far as possible least stressful, just as
24 we did with the patient experience witnesses.

25 All right. 14:03

26
27 That concludes those brief opening remarks and are we
28 ready for the witness, Ms. Briggs?

29 MS. BRIGGS: Yes we are, Chair, yes.

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CHAIRPERSON: Let's get her in.

MS. BRIGGS: For the purpose of the record panel the statement reference is STM-183-1. Evidence of Christine Keenan.

14:03

CHRISTINE KEENAN HAVING BEEN SWORN WAS EXAMINED BY MS. BRIGGS AS FOLLOWS:

1 Q. MS. BRIGGS: Your name is Christine Keenan but you have told me today that you are happy to be known as Christine; is that right?

14:04

A. That's right. Can you speak up because my hearing is not very good.

2 Q. Okay. Let me know if at any time you can't hear what I'm saying. Is that a good volume for you?

14:04

A. Yes, that's good.

3 Q. Christine, we've met earlier, okay. I've explained to you the process in respect of your evidence and the first step in that process is that I'm going to read the statement that you provided into the record, okay. So if you're happy I'll start doing that now?

14:04

A. Okay.

4 Q. "My connection with MAH is that I worked at MAH initially as an enrolled nurse, then as a Staff Nurse, then finally as a behavioural nurse therapist. The relevant time period that I can speak about is between 1973 and 2015, '16. I worked at MAH and then moved to the Iveagh Centre once it opened in 2010.

14:04

1 I began working at MAH as an enrolled nurse, not banded
2 or graded at the time, in or around 1973. I undertook
3 additional training and worked as a Staff Nurse, not
4 banded or graded at the time from 1986 until 1993/
5 1994. I undertook further additional training and 14:05
6 worked as a behavioural nurse therapist Band 7 from
7 1993/1994 until my retirement in 2016.

8
9 My introduction to MAH was as a volunteer with the
10 Gateway Club Larne, a charity or voluntary group run by 14:05
11 [name], who did a lot of charity work and whose
12 daughter had Down Syndrome. He brought me to MAH and I
13 was impressed with the place and the care provided by
14 MAH staff which gave it a family atmosphere. I had
15 intended to do general nursing but realised that my 14:05
16 calling lay in learning disability nursing. Thereafter
17 almost all my nursing career has related to nursing
18 children.

19
20 At the beginning of my career when my children were 14:05
21 young I trained at MAH and worked there as an enrolled
22 nurse and then as a Staff Nurse on night duty. I
23 worked in MAH on the children's wards which were
24 Conicar, C1, C2 and C3. I also worked on occasion with
25 patients from the female hospital ward called the 14:06
26 hospital block.

27
28 In around 1990 I came off night duty. I retrained in
29 the social training centre, MAH, as a behavioural nurse

1 therapist. This enabled me to work as a specialist
2 nurse therapist. I then completed a foundation course
3 in family therapy and a diploma in teaching. I worked
4 with in-patient children and also children from the
5 community on an out-patient basis. I did not retain 14:06
6 any documentation but the dates of my various roles
7 will be found in MAH records.

8
9 The children that I worked with on an out-patient basis
10 were ones who had been excluded from mainstream 14:06
11 education. The patients that I worked with on an
12 in-patient basis had either a mild learning disability,
13 (MLD) or severe learning disability (SLD). The parents
14 would have brought the children to MAH on a daily or
15 regular basis. These parents would not have wanted 14:07
16 their children in care situations. There were only two
17 or three patients like this, P1 and P153 were two of
18 these patients.

19
20 My first impressions of MAH when I began working there 14:07
21 was that the older nursing staff mothered us. By this
22 I mean that I felt that we were well supported."

23
24 You name a sister and you say she was particularly
25 supportive. 14:07

26
27 "The first place within MAH that I worked was Abbey
28 House which consisted of steel Nissan huts. Abbey
29 House was a large room with a stage at one end. There

1 were around 30 children in each ward. I recall singing
2 songs with the children and being caught on stage by a
3 senior nurse."

4
5 who you name.

14:07

6
7 "He was senior to me and I was embarrassed being caught
8 performing to the children but they enjoyed it. We
9 also played with the children on swings, made mud pies,
10 did paper crafts and painted. Before bedtime we sang
11 nursery rhymes and played little games to relax the
12 children. I met my husband through my work at MAH, he
13 was a clinical nurse tutor there. We married in 1975.
14 The social training centre consisted of two large
15 classrooms."

14:08

14:08

16
17 And you say who they were run by.

18
19 "Although they have the same name they were not
20 related. I completed a diploma in education which
21 enabled me to deliver the curriculum to school age
22 patients. While the school age MAH patients had
23 learning difficulties and may have had behavioural
24 challenges we at MAH still had to implement the
25 curriculum and deliver some teaching and ensure that
26 they acquired some skills.

14:08

14:08

27
28 I worked on Conicar Ward as an enrolled nurse in the
29 1970s and then as a staff nurse from around 1992 and

1 felt the overall level of treatment and atmosphere to
2 be good. I felt that it was a good ward to work on.
3 For example, a patient, P1, was admitted to Conicar
4 Ward. He was wearing a facial mask and splints on both
5 his arms and his arms and legs. This was for his 14:09
6 protection as he was intent on injuring himself. He
7 would punch himself and restrain himself by putting his
8 arms behind his back. I worked very hard to address
9 P1's behavioural issues so that these items could be
10 removed. We used redirection approaches, things like 14:09
11 singing, walks and massages. It was almost impossible
12 to work with P1 at times. I could have cried at times.
13 P1 remained needing two MAH staff to be present with
14 him at all times. I remember one incident. I cannot
15 recall when this was, but it was lunchtime in Conicar 14:09
16 Ward and P1 was agitated and was trying to hurt
17 himself. He was doing this by punching himself and
18 kneeling himself in the face. He was hitting his head
19 and biting his tongue. This incident required four
20 members of MAH staff to deal with, I cannot remember 14:09
21 their names. I am referring to this incident as I do
22 not understand what the general public's expectations
23 are and whether they appreciate how challenging it is
24 dealing with people with learning disabilities at
25 times. I and other MAH staff worked very hard with P1 14:10
26 so that he would redirect himself when he felt that he
27 wanted to injure himself. In the end he would use a
28 plastic spatula to flap and this distracted him. He
29 was always accompanied by two members of MAH staff. I

1 understand that he was resettled out of MAH."
2
3
4
5

14:10

6 **Removed at the request of the Chair of the**
7 **Muckamore Abbey Hospital Inquiry**
8
9

10
11
12
13 I remember a patient P154 who was from Ireland. She
14 had previously been in a mother and baby home run by
15 nuns. I cannot recall when she was admitted but I
16 believe it was in the 1970s. She was a lovely child.
17 She was fascinated by mirrors as there had been no
18 mirrors in the convent. P154 really wanted a teddy
19 bear. Myself and a number of my colleagues pooled our
20 money and we went to Alf Giddley's toy shop and bought
21 a panda. When we gave it to P154 she went outside to
22 the swings and tried to put the panda in the swing and
23 push it. She just wanted to take care of something.
24 We ended up having a funny time trying to attach the
25 panda to the swing so she could push the panda without
26 it falling down.
27

14:10

14:11

14:11

14:11

28 Another MAH patient who I particularly recall was P11.
29 He was admitted to MAH when I was on night duty. I

1 cannot recall the precise date but it would have been
2 the mid 1980s. I was asked to help special him, which
3 meant that he required additional nursing care and
4 supervision. P11 was the most beautiful child. He
5 punched his own face and eyes. I, along with other MAH 14:11
6 staff, tried to prevent him from doing this as he was
7 at risk of seriously injuring himself. I tried to sing
8 to him to divert his attention. I prayed for help. It
9 was so physically draining trying to nurse and
10 supervise P11 that we had to rotate staff as it was too 14:12
11 tiring doing it for any length of time."

12
13 You then name a person and you say that she put in a
14 lot of effort in the care of P11. He.." that's P11
15 "Constantly hit himself. She.." that's the person you 14:12
16 named...

17
18 "...had a large rocking Chair made, the orthotics
19 department at MAH to try to soothe him and distract
20 him. After a while we discovered that P11 found being 14:12
21 in water to be calming."

22
23 The person you named...

24
25 "Would be in the pool so often and for so long that we 14:12
26 used to comment that she was turning into a prune.
27 I find it difficult to talk about some of the patients.
28 As mentioned, P11 was a beautiful child and we worked
29 very hard with him. I was not involved with his adult

1 care. I do know that he eventually blinded himself. I
2 found out about P11 blinding himself through punching
3 himself. I am not sure what could have been done to
4 prevent him from blinding himself.

14:13

5
6 It has been difficult for me to hear about incidents of
7 abuse in the media coverage of the MAH Inquiry. I
8 cared very passionately about my work and I would not
9 have stayed if I had seen abuse of patients. I am not
10 sure whether I was treated differently by the other MAH
11 staff, whether they knew that I would not tolerate
12 abuse and so were careful around me.

14:13

13
14 I would say that the physical care at MAH was very
15 good. I did not ever see a bed sore on any MAH
16 patient, however we would sometimes have patients
17 return from other hospitals after as little as two
18 weeks and those patients sometimes had bed sores.

14:13

19
20 I had a lovely, large office in MAH, it was very
21 peaceful and looked out on fields. I could see hares
22 playing in the fields. I would have met patients
23 sometimes with their families there. Sometimes the
24 patients would have been brought to me by MAH staff and
25 other times I would have collected them from the wards.
26 From 9.30 am in the morning the children would have
27 been with me. I delivered work schedules based on the
28 curriculum. After lunch, we had afternoon sessions.
29 On Wednesday evenings I delivered social skills

14:13

14:14

1 sessions to patients. I sometimes had family therapy
2 sessions and we used a two-way mirror so that I could
3 observe the patient with their family and provide
4 guidance. We had supper dances for the patients. The
5 staff got involved and a number of us brought in 14:14
6 ribbons to do the female patients' hair and got them
7 all ready for a special occasion. We had a hospital
8 radio station."

9
10 And you name two people involved with that station. 14:14

11
12
13 "The radio station would play requests for the patients
14 and staff members. I was a hippy and I remember being
15 shocked at people under 30 listening to country music. 14:14

16
17 We would sometimes take the patients to pick their own
18 potatoes at Greenmount Agricultural College, Antrim."

19
20 You name a charge nurse on the ward. 14:15

21
22 "...and then have fresh potatoes. This is another
23 example of the family atmosphere that existed at MAH.

24
25 In relation to standards on wards one aspect of care 14:15
26 that I was not comfortable with was the lower standard
27 of care in the early days as there was less privacy for
28 patients. In the dormitories and in the showers there
29 was less privacy than there is now. For example, we

1 would have to bath ten patients at once. This improved
2 with the refurbishing of MAH. Patients then had their
3 own rooms with their own bathroom facilities en suite.
4 This meant that they had greater privacy.

14:15

5
6 I do not think I ever saw neglect. Had I witnessed any
7 neglect I would have reported it.

8
9 In around 1990 or 1991, the report "People First" was
10 issued by the Department of Health, Social Services and 14:16
11 Public Safety and this triggered a large number of
12 changes in MAH. Some of these changes were minor, for
13 example, meaning we had to stop calling patients
14 "patients" and had to call them "clients" and then we
15 had to re-start calling them "patients". Some of these 14:16
16 changes were more significant for MAH meaning, for
17 example, that the old institutional buildings had to be
18 closed. These were large, red brick buildings with
19 large dormitories. 20 children would sleep in a large
20 dormitory. I understand that these may have looked 14:16
21 imposing but we used to have great fun and deliver
22 great care in them. I put the children to bed and
23 sometimes we pushed all the beds together and I read
24 stories and recited nursery rhymes with them. The more
25 senior MAH nurses would come around to check that 14:16
26 everyone was in bed and was asleep and they would find
27 me reading stories. I feel that these old buildings
28 lent themselves to a better sense of community. The
29 older buildings were replaced with self-contained units

1 and I feel that this is isolated the MAH patients
2 somewhat. I do not know who made these decisions.

3
4 My patients at MAH had a range of activities that they
5 participated in, namely walks were very popular and 14:17
6 everyone went on walks frequently on around a daily
7 basis. We had a film club and frequently, around a
8 weekly basis, which showed films. Every Saturday mass
9 was held in MAH so that MAH patients could attend. On
10 Sunday we had church that MAH patients could attend. I 14:17
11 recall that a number of patients went to both mass and
12 church. The patients seemed to enjoy church had as it
13 had an organ and there was music at it. We had a group
14 of MAH patients who played pool. The patients
15 participated in pool/snooker competitions in England 14:17
16 and won prizes there. We got them waistcoats and bow
17 ties to wear. I recall that the awards were put into
18 an award cabinet.

19
20 Each month MAH would have a supper dance. Once per 14:18
21 year we had a special Indian event where Indian
22 musicians would come in and play for the MAH patients.
23 There were catering options including the Cosy Corner,
24 a canteen located in MAH, and there were vending
25 machines with drinks and snacks. MAH patients met with 14:18
26 their girlfriends and boyfriends. There were a number
27 of romances between patients at MAH. Two patients
28 eventually married.

1 On the first Saturday in June each year there was a
2 gala day which was attended by MAH staff, patients and
3 their friends and families. This was a wonderful event
4 and had a lot of community support. MAH staff all got
5 involved in this. I brought in ribbons for some of the 14:18
6 MAH female patients' hair. The Army came along to meet
7 everyone. There were donkey rides, cake sales and
8 bric-a-brac. This day served as a fundraiser and the
9 money raised was used to pay for days out for MAH
10 patients. These days out included trips to Bangor and 14:18
11 Portrush.

12
13 There was a ladies' football team that patients could
14 join. They were very good and played in many
15 competitions. 14:19

16
17 All of these activities were removed as part of the
18 modernisation of MAH. I think MAH patients had a
19 better patient experience before these changes.
20 Patients had greater opportunities to develop various 14:19
21 skills such as social skills and domestic skills. The
22 removal of these at MAH meant that the patient
23 experience was diminished.

24
25 There were some patients who were at MAH, not because 14:19
26 of the MAH's staff's decisions but because there were
27 no suitable locations for them to be housed in the
28 community. For example, I recall a number of patients
29 with needs such as behavioural issues who also had

1 learning disabilities as well as superimposed mental
2 health problems. It was challenging to go resettle
3 these patients because of their complex needs. With
4 the development of MLD and SLD schools these patients
5 who would have been at MAH could now be resettled and
6 educated in the community. 14:19

7
8 I did not work with forensic adult patients. I do not
9 know how many MAH staff dealt with them and I do not
10 know what training they had to deal with these 14:20
11 patients. I did not have any training to deal with
12 forensic adult patients.

13
14 There were a few forensic child patients at MAH. I
15 recall one whose first name was P155 who was quite high 14:20
16 functioning and who had Smith-Mageni's syndrome. He
17 wrote very sexualised letters to members of staff and
18 he threatened to rape me. He was of a larger build so
19 was a risk and he was always nursed or supervised on a
20 one to one or even two to one ratio. He stubbed 14:20
21 cigarettes out on nurses' heads. I remember one very
22 serious incident, I do not recall the date, a number of
23 staff were responding to an alarm for another patient
24 and while they were dealing with that patient, P155 was
25 being nursed or supervised by two nurses called H727 14:20
26 and H728. P155 assaulted H728, smashing her face with
27 his knee and pinning her to the floor.
28 He was eventually sent to a facility somewhere..."
29

1 And you say where that is.

2
3 "I do not think H278 ever went back to nursing.

4
5 I make a general observation here in that were this 14:21
6 incident to happen in a general nursing setting it
7 would be on the news. As this incident happened in a
8 learning disability nursing situation, the public never
9 hears about it. The fact that the public do not hear
10 about these assaults annoys me. 14:21

11
12 I wrote behaviour programs for MAH patients. These
13 programmes were included in their patient notes and
14 were available to all MAH staff. In writing these
15 programmes, I would look at the patients antecedents, 14:21
16 the frequency of incidents, the intensity of incidents
17 and the various things that would impact the a
18 patient's behaviour. This included looking at a range
19 of factors, including family relationships,
20 relationships with MAH staff and the patient's own 14:21
21 surroundings.

22
23 During my time at MAH, physical intervention training,
24 in MAPA for example, became increasingly prevalent in
25 the training and development of staff. This was due to 14:22
26 increased aggression by patients and lack of
27 opportunities for patients created by policy changes at
28 government level. In my view, physical intervention is
29 sometimes necessary to avoid serious risk of harm, but

1 it is not necessary in all circumstances and should be
2 used as a treatment of last resort. I feel that with
3 the training and physical intervention this became more
4 used. Conversely, staff did not have behavioural
5 training so were not equipped to use diversionary 14:22
6 strategies to divert patients away from causing harm to
7 themselves, other MAH staff, or patients or property.
8 Staff were given some training in diversionary
9 strategies and children would have had behavioural
10 support plans which staff would have had access to. 14:22

11
12 I remember one incident, although I am not sure of the
13 date, when a patient, P115, bit on the arm a member of
14 MAH staff, H729, he then got her into a headlock. She
15 was at risk of serious injury. I distracted him and he 14:23
16 ended up chasing me around the gym. I love running and
17 he ended up running until exhaustion after around 25
18 minutes. With P115 physical intervention did not work
19 and, for him, he found playing with someone else's
20 fingers to be relaxing and distracting. 14:23

21
22 I attended my general practitioner due to injury
23 sustained at work. He asked me why I stayed at my job
24 at MAH. As a Christian I felt at the time and since
25 that MAH was where I was meant to be. 14:23

26
27 I was informed at one stage by a staff member of the
28 Belfast Health and Social Care Trust that I was the
29 most injured member of staff within the Trust area. I

1 cannot recall when that was or the name of the member
2 of staff who told me that.

3
4 I remember an MAH patient named P34. He was the most
5 loveable child. His mother and I have kept in touch. 14:24
6 I recall him being admitted as a child. He was a
7 beautiful child and a real character. He used to wink
8 at me. I felt that he was well supported in children's
9 service in that he received good care which supported
10 his development and needs. I used behavioural 14:24
11 techniques with him. Seclusion, as in the use of the
12 seclusion room, and physical intervention would not
13 have worked with him. To me, isolating someone causes
14 other difficulties and problems, but sometimes it is
15 necessary. P34 was not able to communicate his 14:24
16 feelings and when he became frustrated he would use his
17 behaviour to communicate. For example, he became
18 agitated and frustrated. He expressed this by taking a
19 fire extinguisher off the wall and throwing it at me.
20 It landed inches from me. I had to sit down because of 14:24
21 the shock. Had the fire extinguisher hit me, I believe
22 that I would have been seriously brain damaged or
23 possibly dead. Harming me would not have been P34's
24 intention, he simply wanted to throw things for
25 attention and to express himself. " 14:25
26

27 At paragraph 33 then, which I am not going to read in
28 full, you refer to another patient who you say was a
29 difficult and aggressive child and you describe

1 incidents where you were assaulted and threatened by
2 that patient. Picking up towards the end of paragraph
3 33, you say:

4
5 "I was treated at Antrim Area Hospital for eye 14:25
6 injuries. I was off work for a period of around six
7 weeks. This incident triggered panic attacks and I
8 returned to work on a phased basis which included
9 working with adults.

10
11 I worked with another patient during this period whose 14:25
12 nickname was "happy feet" as he was always happy. I
13 cannot recall his actual name but I do recall that his
14 brother was a famous footballer. He was a lovely,
15 funny man. I recall baking with him and he really 14:25
16 loved this. I taught him how to make a small meal for
17 himself. How to go to Tesco and how to budget and
18 order a meal in a restaurant.

19
20 Most of the time when we were injured we would not have 14:26
21 filled out accident forms as it would have taken too
22 long. The accident forms were time consuming to
23 complete. I filled out forms when the injuries were
24 more significant. If I was given a slap or was hit by
25 patients I would not have always reported this. I 14:26
26 think I was injured hundreds of times.

27
28 My work at MAH had an impact on my family. My eldest
29 child, my daughter, said that she hated my job as she

1 saw my injuries. I disliked the impact that my work at
2 MAH had on my family.

3
4 My son got married in 2010. In the run up to my son's
5 wedding he told me I needed to stay away from the MAH 14:26
6 patients who were prone to physical outbursts. He said
7 that he did not want his wedding photos to have me
8 showing me having facial injuries. Shortly before the
9 wedding I was assaulted by a patient and broke my
10 scaphoid bone. This required me to have a plaster 14:26
11 cast. I had to ask for this to be removed prior to the
12 wedding so that it would not be in the photos.

13
14 In relation to support for staff, I found MAH to be
15 difficult at times. The work was demanding and we were 14:27
16 always busy. Patients could be demanding and
17 challenging to deal with and to nurse. I felt that I
18 had a free reign in the delivery of my behavioural
19 nursing services because I got on well with the parents
20 because I got results with the patients. Patient's 14:27
21 parents were pleased with the progress that their loved
22 ones made.

23
24 In relation to other MAH staff I raised issues around
25 food and this got me into trouble. I was concerned at 14:27
26 the quality of food being provided to MAH patients. I
27 thought the food was rubbish, essentially junk food.
28 Other MAH staff knew that I could be challenging but
29 that I was honest and true. For example, when I raised

1 the issues about the patients' food I was told by H359
2 to apologise. I refused to do this. Shortly
3 afterwards Jamie Oliver did a lot of publicity about
4 poor quality hospital food. H359, in response to my
5 comments, created a working party which looked at
6 healthy eating. 14:28

7
8 I received the Farmer Prize two years in a row for my
9 development of the Picture Exchange Communication
10 System, PECS, at MAH. I had been nominated for this by 14:28
11 the consultants at MAH. I received Learning Disability
12 Nurse of the Year in 2008. This was very special as I
13 had been nominated by parents of patients at MAH. The
14 awards were a lovely evening at the Culloden Hotel,
15 Cultra, and had television cameras. I was shocked when 14:28
16 I won and did not have a speech prepared. Another MAH
17 nurse [name] was also nominated. I thought he was a
18 great nurse as he was very caring.

19
20 In relation to the approach to patients and information 14:28
21 about patients, I felt that I was clear on the reason
22 for patients' admissions. My role meant that I was
23 involved in the admissions process and I attended
24 multidisciplinary team meetings. I conducted home
25 visits to people in the community. These home visits 14:29
26 were required to assess whether someone needed to be
27 admitted to MAH. This was the normal route to
28 admission to MAH for the patients whose care I was
29 involved in. I recall that there were a few emergency

1 admissions, but this was a relatively rare occurrence.
2 I remember two emergency admissions. The first parent
3 was P156 whom I recall trying to run away from MAH.
4 The family found it difficult managing P156. I cannot
5 recall the date of her admission. 14:29

6
7 The second patient was P77. I recall his admission
8 which was in around 2000. I had carried out a number
9 of home visits and the family found it very difficult
10 managing P77. P77's siblings would sleep in the attic 14:29
11 at night due to P77's behaviour.

12
13 In the first few weeks following a patient's admission
14 I was involved in the assessment process. I carried
15 out functional analysis and a historic assessment. 14:30

16 This involved getting details about the patient's
17 birth, illnesses, genetic factors, acquired injuries
18 and considering the patient ease family and
19 relationships. I assessed patients using a number of
20 tools, including adaptive behaviour scale, personal 14:30
21 education plan, motivational assessment scale and
22 reviewing a patient's circle of friends. I also used a
23 risk assessment tool which I designed myself. My
24 assessment resulted in a behaviour management plan
25 which was included in the patient's notes and records 14:30
26 accessible by all members of MAH staff. Sometimes my
27 plan would be to treat the most serious and urgent
28 behaviours. Other times my plan was to treat some of
29 the easiest first, to build confidence and rapport.

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In the media coverage of the MAH Inquiry I have heard a lot said about the use of seclusion rooms. There were no seclusion rooms on any of the children's wards. There was a seclusion room on Six Mile ward. This was the only seclusion room of which I was aware. I have heard criticism in the media coverage of the MAH Inquiry that there were no toilet facilities in the seclusion room. I would respond by saying there were toilet and shower facilities beside the seclusion room on Six Mile ward. On a practical point, I have had a toilet removed from the wall by a patient and thrown at me so this was a serious risk. I cannot recall the date of this incident or the name of the patient. Seclusion rooms were specially made without edges, corners and skirting boards, for example, as these posed risks to the patients. The padding and mats were specially sealed so that patients could not rip them apart and eat them or cause other harm to themselves.

Patients were placed in a seclusion room when they were a risk to themselves or others. They were placed there by MAH staff and supervised. Seclusion rooms offer a place where patients can be safe and can calm themselves. When considering seclusion rooms, I would like the MAH Inquiry to consider the following: When you are in a bad temper, what do you do? You do not stay in a crowded room of people. You self-regulate and take yourself out of the situation so that you calm

1 down. This is self-regulation and a number of the MAH
2 Inquiry patients could not do this.

3
4 Upon reflection, in light of what I have heard from the
5 evidence during the MAH Inquiry, I am now not sure what 14:32
6 the families of MAH patients expected of the MAH staff
7 in relation to care. The patients in MAH are people
8 who could not be cared for by their families and could
9 not be cared for in the community. The patients in MAH
10 were challenging. I have received a large amount of 14:32
11 verbal abuse throughout the years, including of the
12 most serious kind. I recall one MAH patient shouting
13 "I wish your husband dies". I recall one patient
14 pinning me to a wall. I have been grabbed, hit in the
15 face and told by an MAH patient that he was going to 14:33
16 rape me.

17
18 I ran a social skills group on Wednesday evenings in
19 MAH. I believe that leaving social skills training
20 until people with learning disabilities are adults is a 14:33
21 mistake. I introduced MAH patients to some simple
22 social skills like how to queue, how to introduce
23 themselves and how to order a meal in a restaurant.
24 I did a lot of baking with MAH patients. I used this
25 as a form of treatment and engagement. This was a 14:33
26 positive sensory experience, with something tasty to
27 eat at the end. I taught MAH patients how to do simple
28 things like how to butter bread and how to wash dishes.
29 Cookery was a way of rewarding positive behaviour. I

1 had a points system where positive behaviours received
2 points and the points could be used to make things like
3 chocolate muffins.

4
5 In around 2008 we set up a car wash at MAH. MAH 14:33
6 patients and MAH staff worked as a team to wash cars
7 and received a payment in return. I felt that this was
8 an important part of normalisation. It helped MAH
9 patients understand that in return for doing a task
10 they received a reward. The money that was earned from 14:34
11 car washing was kept in a jar and the patients decided
12 what they would spend it on. They would have selected
13 things like ten pin bowling, a cinema trip or go to
14 McDonalds.

15 14:34
16 A number of MAH staff and I had circle time with the
17 children every day and we used primary movements. This
18 involved acknowledging and encouraging positive
19 behaviours. We talked about the good things and bad
20 things that we did at the weekend. This involved MAH 14:34
21 staff sharing their own experiences. For example, I
22 may have said to the children that I was grumpy with a
23 member of my family. This was also a way of building
24 trust with patients.

25 14:34
26 Looking back on my career at MAH I think that one of my
27 greatest successes as with a patient called P157. I
28 worked with P157 for around three years immediately
29 prior to my retirement in 2013. P157 was a very

1 difficult patient who had autism and obsessive
2 compulsive disorder. His behaviour included
3 dismantling things. His father and his mother would
4 have had to call a plumber at least once per week. H
5 would also bite people's noses and grab people between 14:35
6 the legs. This was particularly distressing for some
7 of the staff. He tried to take out his own clavicle
8 bones on one occasion. I was able to manage his
9 behaviour by doing baking with him. I made scones with
10 him and he never once tried to bite me. P157 also 14:35
11 reacted well to social skills training. We had a range
12 of rules and I understood him well. We would sometimes
13 take all the books off the shelves and P157 would love
14 to arrange them back in order. I remember one
15 particular breakthrough that I had with P157. It does 14:35
16 not sound like much to many of us but I met with P157
17 and his father and we put on aprons, each of them at an
18 end of the bench, and they made buns. This was a major
19 achievement for them and marked an improvement in their
20 relationship. P157 called me "Queen Christine" and he 14:36
21 is now living very successfully in the community in
22 supported living.

23
24 There was a push to resettle patients from MAH in the
25 2000s. I advised patients' parents that they did not 14:36
26 have to accept anything if they did not feel it was
27 right for their loved one. I felt that it was
28 sometimes my position to advocate for them. I printed
29 out bits of "People First" and other pieces of

1 guidance. I gave these to parents so that they
2 understood their rights. I think that the families
3 appreciated this. I think that the other MAH staff
4 felt that I was very dedicated. I felt that I had to
5 be an advocate for those patients who were struggling. 14:36

6
7 I did not have any say on medication of patients.
8 However, consultants may have considered my views at
9 looked after children and multidisciplinary meetings.

10 I had no input into the use of PRN. However, I looked 14:36
11 at the use of PRN post-use and considered whether there
12 were any learnings from incidents. These reviews
13 included me looking for learnings and understanding of
14 factors that led to the incidents and/or use of PRN. I

15 also made recommendations about how to deescalate in 14:37
16 the future. My recommendations were put into a risk
17 assessment which was a form that I had designed. This
18 included a process of assessment, delivering a planned
19 programme, evaluating the effectiveness of the plan and
20 reassessing. I looked at restrictive practices and 14:37

21 considered and made recommendations about redemptive
22 approaches for the patients. This information was
23 available to all staff. These recommendations were
24 implemented by staff caring for patients.

25 Implementation of these recommendations were carried 14:37
26 out by the named nurses for each patient and consistent
27 with the behavioural support plans.

28 In relation to ward allocation, patients under 18 years
29 of age stayed on children's wards.

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In relation to CCTV, there were no CCTV cameras in MAH when I worked there.

Children's services were moved from MAH to the Iveagh Centre, part of the Royal Victoria Hospital Belfast in around 2010, this was a significant change. I moved from being surrounded by fields and peace and tranquility to a flashpoint. The Iveagh Centre is located in an interface area, meaning it had the potential to become violent. I was surprised at the large number of flags in the environment.

14:38

14:38

At MAH the staff and I had to build up our children so that they could lead the best lives that they could lead. I found it difficult to leave MAH as I found my work with patients very rewarding. I felt that this was my calling. Now, with the ongoing MAH Inquiry, I find it difficult to say that I worked there. I had been proud of my work at MAH. Now I am not sure when and where I can talk about my nursing career."

14:38

14:38

Over the page then on page 20 you sign and date that statement, Christine, okay.

14:39

I am going to take you back to paragraph 21 because before I have you adopt the statement formally, we had noticed an error in respect of your statement, a typographical error, if we put it that way at paragraph

1 21 on page 7, the numbers are at the top Christine.

2 A. Yes.

3 5 Q. Okay, that should read:

4

5 "We would sometimes take the patients to pick their own 14:39

6 potatoes at Greenmount Agricultural College Antrim."

7

8 You name a nurse who was the charge nurse on the ward.

9 That should be a full stop and then said "we then had

10 fresh potatoes" is that right? 14:39

11 A. Yes.

12 6 Q. Christine are you content to adopt the contents of that

13 statement as it is to the Inquiry?

14 A. Yes.

15 7 Q. I am going to start by asking you a little bit about 14:39

16 your most senior position and the position you spent

17 the most time in, which was as a behavioural nurse

18 therapist okay?

19 A. Yes.

20 8 Q. That was a Band 7 role; isn't that right? 14:40

21 A. Band 7 role, yes.

22 9 Q. You were in that role, am I right, between 1993, 1994,

23 until 2010 when you moved to the Iveagh Centre is that

24 right?

25 A. Yes. 14:40

26 10 Q. And throughout that whole period you were a behavioural

27 nurse therapist?

28 A. Yes, I done most of my training during that period of

29 time, over that period of time.

1 11 Q. Your job title during that time would have been
2 behavioural nurse therapist?

3 A. Behavioural nurse therapist, yes.

4 12 Q. Could you very briefly describe what a behavioural
5 nurse therapist does?

14:40

6 A. Right, we would have looked at, because I worked with
7 children, it was always children that I was with so
8 children, the youngest child I ever worked with was I
9 think maybe around about 2 years of age, the only one
10 ever that came into the hospital at that age. But most 14:40
11 of them were around young teenage years, from maybe 10
12 years of age up to 18 years of age. The children would
13 have been referred to us either by social workers or by
14 the school, by parents or from the GP to the
15 multidisciplinary team. I was tasked usually to go out 14:41
16 to assess that child, so I would have gone out to the
17 child's home or to the school or to, if they were maybe
18 in a respite care facility, to assess the child. We
19 would have brought back the information and from the
20 multidisciplinary team meeting there was a decision 14:41
21 made whether the child was suitable for admission into
22 the care setting. Sometimes we felt that a child could
23 be looked after, maintained at home and in school. At
24 other times, because the behaviour was very difficult
25 and sometimes it's hard to change a behaviour if they 14:41
26 stay in that same setting so we have to change the
27 environmental setting to relook at the behaviour. So
28 my job was to assess and then to programme plan. So I
29 would have programme planned for the children.

- 1 13 Q. If it was deemed that a child didn't need to be
2 admitted to Muckamore, would you still have had a role
3 in relation to that child on an out-patient basis, is
4 that fair to say?
- 5 A. If I was, yes, I could have seen them on out-patient 14:42
6 basis as well.
- 7 14 Q. Where would that have taken place, in the home or in
8 Muckamore, in the day care centre or where would that
9 have been?
- 10 A. There were children who came in, we only had a few 14:42
11 children who came in on a daily basis, they would have
12 lived at home and came in on a daily basis and then
13 gone home again every evening. The majority of
14 children that were admitted into Muckamore stayed
15 there, maybe went home at weekends or maybe once a 14:42
16 month. Some of them went home every weekend, some of
17 them once a month.
- 18 15 Q. You talk in your statement about writing behavioural
19 plans and behavioural programmes you call them?
- 20 A. Yes. 14:42
- 21 16 Q. I want to ask you about how effectively they were
22 implemented because you say they were included, those
23 behavioural programmes in patient notes, and were
24 available to all of the staff?
- 25 A. Yes. 14:42
- 26 17 Q. But are you aware as to how well they were put into
27 practice by the staff who would be looking at those?
- 28 A. When a behavioural programme, when you design a
29 behavioural programme there is a lot of assessment work

1 goes in prior to that, so the staff would have been
2 involved in that assessment work. They would have been
3 tasked to look at the motivation assessment scales.
4 The staff were involved in the assessment process.
5 When we completed the assessments and we looked at the 14:43
6 behaviour support plan, they were worked along with the
7 staff that were working with the child and they were
8 taught. If there was specific issues that we needed to
9 look, I would have been doing direct treatment with the
10 child, so we would have worked along with the child 14:43
11 with the nursing staff as well. On some occasions we
12 would have had direct teaching sessions, if we were
13 implementing a communication system like PECS, we would
14 have done training sessions with the staff as well.

15 18 Q. would you have been satisfied then that whatever you 14:43
16 put into the programme was actually being implemented
17 on the ground when you weren't around?

18 A. Usually, yes it was, because we had the children's LAC
19 Review meetings, or we had team meetings every week and
20 we would look at how the programme was being 14:44
21 implemented, if things were working. Sometimes we
22 would find the staff, we would report back that
23 something really wasn't working, so we had to readjust
24 again. Because once you right write a programme it
25 doesn't always follow that the child is going to fall 14:44
26 in with the programme, you had to readjust again to
27 suit in with the child's needs and with the staff.

28 19 Q. You refer to "we". who are you referring to when you
29 say we would have to look at it again if staff reported

1 there was a problem?

2 A. The staff because every child had a named nurse and
3 then they had a team that would work with them, we
4 would have liaised with the named nurse, because they
5 were with the child maybe more on the ward basis 14:44
6 because I wasn't always based on the ward.
7 CHAIRPERSON: Can I just ask, my two colleagues will
8 know this very well, but can you give me an example of
9 what might go into a behavioural programme?
10 A. Sorry? 14:44
11 CHAIRPERSON: Can you give me an example of what might
12 go into a behavioural care programme.
13 A. What would go into a behavioural care programme?
14 CHAIRPERSON: Yes.
15 A. When you look at the behavioural programme initially 14:45
16 you are looking at, you have to identify the behaviour
17 first of all, so you are identifying that particular
18 behaviour. There could be a range of behaviours. So
19 you look at that behaviour, you look at the antecedent
20 for their behaviour, what their behaviour is, what they 14:45
21 actually do during that behaviour.
22 CHAIRPERSON: So it might be, what, putting something
23 in your mouth or it might be, what sort of thing would
24 it --
25 A. What sort of behaviours? Mostly the children that 14:45
26 would come to us would have, their behaviours would be
27 quite difficult, so you had to look at that behaviour.
28 It could be, I'm trying to think of something,
29 self-injurious behaviour, where a child would be self-

1 injurious. So we were looking at maybe what triggers
2 that self-injurious behaviour. So they could be
3 punching themselves, pulling their hair, banging their
4 head off the floor, jerking themselves. We are looking
5 at that behaviour and what is the antecedent for that 14:45
6 behaviour and then the consequences of the behaviour.

7 CHAIRPERSON: The plan would be how to respond to that
8 behaviour?

9 A. How to respond. You look at how you can change the
10 antecedent and the consequence for -- those are the two 14:46
11 things that maintain the behaviour, the antecedent and
12 then the consequence. You look at what you can
13 manipulate and can change about that behaviour. We had
14 to look at it in a very ethical way, in why we were
15 changing the behaviour, if the behaviour was functional 14:46
16 for that person. So if a behaviour, somebody was using
17 the behaviour to gain attention or to communicate
18 something, like sometimes children would use their
19 behaviour if they were wanting to get a drink, but they
20 didn't know how to communicate that. We had to look at 14:46
21 the whole function of their behaviour and look at what
22 we could replace that behaviour with.

23 CHAIRPERSON: Thank you.

24 A. Look at what we were replacing was better for that
25 person. 14:46

26 CHAIRPERSON: Thank you, okay, sorry Ms. Briggs.

27 20 Q. MS. BRIGGS: I am going to ask you now about the wards
28 that you worked on okay?

29 A. Mm-hm.

- 1 21 Q. You tell us in your statement about the children's
2 wards, the wards that you worked on, it was Conicar,
3 C1, C2 and C3. What were the staffing levels like on
4 those wards comparative to the number of patients on
5 them? 14:47
- 6 A. When I was working on those wards, it was going right
7 back in before I started as a behavioural therapist.
8 Those wards were the big red brick building wards and
9 they were quite full of patients at the time. The
10 staffing levels, I'm trying to remember back, maybe 14:47
11 there would have been quite a number of staff on the
12 wards and they were very busy, very busy wards. But
13 they were always, particularly in the children's wards,
14 they were always very happy places.
- 15 22 Q. Were you satisfied that there was enough staff to 14:47
16 handle the number of patients that were there?
- 17 A. Yes.
- 18 23 Q. And you mentioned there that you were working on those
19 wards before you were a behavioural nurse therapist.
20 Can I take it when you became a behavioural nurse 14:47
21 therapist, you are working across more wards than that,
22 is that the case?
- 23 A. Sorry?
- 24 24 Q. You mentioned in your evidence there that you were
25 working on those specific children's wards you said in 14:48
26 your answer, before you came a behavioural nurse
27 therapist?
- 28 A. Yes.
- 29 25 Q. When you became a behavioural nurse therapist were you

1 working in different wards or more wards?

2 A. No.

3 26 Q. Those same wards?

4 A. Whenever I became a behavioural therapist I was based
5 in the social Training Centre. We had rooms like large 14:48
6 classrooms so the children would come from the wards to
7 us. We would have picked them up in the morning time
8 and brought them to the classrooms, taken them back at
9 lunchtime, picked them back up again and brought them
10 back again so they were back and forward. I would have 14:48
11 been on the ward sometimes to help out maybe if they
12 were short staffed maybe to supervise over lunchtime or
13 something, but other than that, I didn't work in the
14 general wards.

15 27 Q. Okay. That's helpful, thank you very much. And it's 14:48
16 right to say that you also worked with adults as well
17 at times, I think you mention that in your statement?

18 A. In some cases, there was one stage where we actually
19 had to work with adults after the children went back to
20 the ward at 3 o'clock and we were tasked to work to 5 14:49
21 o'clock so then we had some adults that we were
22 bringing in at that time.

23 28 Q. Those were adults that were engaging in behavioural
24 therapy would come to you, is that the right way to put
25 it? 14:49

26 A. They would come normally to us, but they were never --
27 we didn't have adults there when we had children there,
28 they weren't allowed to mix.

29 29 Q. DR. MAXWELL: But you didn't work on the adult wards?

1 A. Pardon?

2 30 Q. DR. MAXWELL: You didn't work on the adult wards. The
3 adults came to you in the Social Training Centre?

4 A. The adults came to us, yes, we didn't work on the
5 wards. 14:49

6 31 Q. MS. BRIGGS: were there behavioural nurse therapists
7 that worked on ward, be it in childrens' wards or in
8 adult wards?

9 A. There was no behavioural therapists on the children's
10 ward, no. The adult services did have behavioural 14:49
11 therapists as well, they had two trained behavioural
12 therapists and two assistants.

13 32 Q. were those individuals placed on the wards, can you
14 say, if you can't, that's okay?

15 A. I think they worked on the wards at some stage but they 14:50
16 weren't based on the wards at that time, no.

17 33 Q. When you say at that time, do you mean the time when
18 you worked in Muckamore?

19 A. Pardon?

20 34 Q. When you say at that time -- 14:50

21 A. At that time when I worked in Muckamore, yes, they
22 weren't there.

23 35 Q. The Inquiry has heard some evidence about children
24 being placed on adult wards, being admitted to adult
25 wards. were you aware of that? 14:50

26 A. Yes, there were a number of, well two children that I
27 know of that had gone into adult wards and in those
28 cases it was because their behaviour was so difficult
29 that they couldn't really be managed within the

1 children's ward and the children that were in the
2 children's, they were, children were at risk from that
3 behaviour.

4 36 Q. Okay. I want to ask you --
5 A. They weren't young children, they were children maybe 14:50
6 coming up to 18.

7 37 Q. Okay, I want to ask you then about admissions, okay,
8 because you describe your role in admissions and in
9 fact you have given oral evidence today already about
10 your role in admissions, okay, and you described 14:51
11 carrying out home visits to assess whether someone, a
12 child, needed to be admitted to Muckamore?

13 A. Yes.

14 38 Q. What was the criteria for admission to Muckamore as an
15 in-patient? 14:51

16 A. Generally the criteria was if the child wasn't being
17 able to be managed at home, if their behaviour was
18 causing such a disruption within the home environment
19 with the parents or the siblings or the school couldn't
20 manage the behaviour within the classroom setting of 14:51
21 the school. Sometimes if I went out to a classroom
22 setting, it could have been very difficult for a
23 teacher, classroom assistants to manage that behaviour
24 within that setting and it was having a detrimental
25 effect, the behaviour was having a detrimental effect 14:51
26 not only on that child but the other children in the
27 classroom. And a lot of, in many instances the
28 behaviour was blocking the child's potential to learn
29 so we had to look at the behaviour so the child could

1 learn and develop.

2 39 Q. Thank you, Christine. What about adult admissions
3 then. Would you be aware whether there was a
4 behavioural nurse therapist who was carrying out a
5 similar role to you in respect of adults? 14:52

6 A. I was never involved in adults' admission.

7 40 Q. Okay. And you described in your statement how you were
8 involved in the assessment process after the first few
9 weeks of admission during that initial period when a
10 child is admitted? 14:52

11 A. Mm-hm.

12 41 Q. I want to ask you about the family side of things
13 during those initial few weeks after a child is
14 admitted to Muckamore. The Inquiry has heard evidence
15 that families were told not to visit during those 14:52
16 initial number of weeks. What was the rationale for
17 that?

18 A. With the children?

19 42 Q. Yes, so the Inquiry has heard evidence that on
20 admission to Muckamore a family may not have been 14:52
21 permitted to visit in the first number of weeks and the
22 Inquiry has heard evidence about that in relation to
23 children and adults, okay. Were you aware of that
24 practice first of all?

25 A. Not with the children. 14:52

26 43 Q. Not with the children?

27 A. Not with the children, no. The parents would have been
28 encouraged to be -- to see the children.

29 44 Q. That would have been for the period you were working in

1 Muckamore, the whole time you were there?

2 A. Yes.

3 45 Q. Thank you, Christine. And what about the support that
4 was offered to families whose loved one was admitted to
5 Muckamore? For example, what were they informed about 14:53
6 the likes of advocacy services, can you speak to that?

7 A. Well the parents were always encouraged to be part of
8 the children's LAC review, the children that were
9 there. They had access to advocacy services, I know
10 the children did have. The parents were fully involved 14:53
11 in their care because any behavioural support plan had
12 to be, the parent had to be comfortable with that as
13 well, they had to be able to implement that at home, so
14 they would have been fully involved in that and they
15 would have attended the meetings. So they would have 14:53
16 been there, generally the parents were there on a
17 monthly basis and they were part of the meeting or any
18 other time that they need to be there. And certainly
19 the parents could have seen us at any time if they
20 wanted to speak to me, if they wanted to go through 14:54
21 anything, they could have met with us or if they wanted
22 to see the consultant.

23 46 Q. Did parents or family members of child patients, did
24 they regularly do that, did they come to you and seek
25 that kind of help? 14:54

26 A. Yes.

27 47 Q. We touched on advocacy services there briefly and if I
28 digress for a moment just on to advocacy generally, was
29 the presence of advocacy groups felt as a staff member,

1 did you feel their presence at Muckamore?
2 A. I didn't so much at Muckamore but when we went to the
3 Iveagh Centre we had more involvement with the advocacy
4 services.
5 48 Q. And in terms of visitation then on the children's wards 14:54
6 for parents after those initial period, how often was
7 visitation, were there rules around that or was
8 visitation allowed whenever parents wanted it?
9 A. Generally the parents came whenever they wanted to
10 come. we would have parents come up to take their 14:55
11 children out for the afternoon, out to the Cosy Corner,
12 out for a walk. A lot of the children went home at
13 weekends, their parents would have come up and taken
14 them home for weekends.
15 49 Q. Were visits ever restricted for any reason? 14:55
16 A. Not that I ever knew of.
17 50 Q. And the Inquiry has also heard some evidence about the
18 lack of ability to go and see where patients slept,
19 their rooms, their beds, actually where they were. Was
20 that what it was like on children's wards can you speak 14:55
21 to that, were parents allowed?
22 A. I wasn't aware of that. I think that the parents were
23 allowed to see around, they were shown around the ward.
24 I know certainly within the Iveagh Centre, the children
25 were taken around -- they were taken to the child's 14:56
26 room. A lot of the parents were able to put things
27 into the room that they wanted to put into the room.
28 We had some parents that preferred to take their
29 children's clothes home themselves to wash them,

1 because they felt that they were still caring for their
2 child if they were doing that, that was actively
3 encouraged. A lot of parents put in particular food
4 stuffs that they wanted their children to have.

5 51 Q. That was the situation in Iveagh, can you speak to what 14:56
6 it was like in Muckamore?

7 A. The same in Muckamore, the same in Conicar in
8 Muckamore.

9 52 Q. I want to ask you about what Muckamore was like for the
10 staff who worked there, okay. First of all, what were 14:56
11 the arrangements for clinical supervision within
12 Muckamore? And the Inquiry specifically is looking at
13 the period 1999 onwards, okay, you left in 2010. So if
14 you think about that period 1999 to 2010, what were the
15 arrangements for your clinical supervision for example? 14:56

16 A. I had clinical supervision by the psychology department
17 so I was supervised by a grade higher than myself from
18 psychology because I worked under Psychology at that
19 time.

20 53 Q. Was that clinical supervision effective or not 14:57
21 effective in your view?

22 A. It was grand because we got to talk about our work and
23 about what I was doing and what I wanted to improve or
24 what were my goals for my, for the work I was doing.

25 54 Q. Okay. You describe in your -- I am going to pass over 14:57
26 to Dr. Maxwell.

27 55 Q. DR. MAXWELL: You probably remember, as I do, there was
28 a big introduction of clinical supervision for all
29 nurses in, I think it was around '92, '93, '94. Do you

1 know what sort of supervision the ward nurses were
2 getting in terms of clinical supervision?

3 A. They also supervision.

4 56 Q. DR. MAXWELL: How did that work, who was providing it,
5 how often did they get it? 14:57

6 A. In the wards it would always be somebody of a grade
7 higher than you. If it would have been a staff nurse,
8 it would have been a senior, maybe the charge nurse or
9 the ward sister that would have done the supervision.
10 Generally it was always maybe the charge nurse or ward 14:58
11 sister being supervising or doing it with the nursing
12 staff or senior staff nurse.

13 57 Q. DR. MAXWELL: So it was individual because there were a
14 couple of different models, some places had group
15 supervision, some had individual supervision, are you 14:58
16 saying it was individual?

17 A. I think it was nearly all individual. I know certainly
18 my supervision was always individual.

19 58 Q. DR. MAXWELL: Did you have supervision before you made
20 the transition to be a behavioural nurse therapist, did 14:58
21 you have clinical supervision when you were working as
22 a Staff Nurse on the ward?

23 A. When I was staff, they didn't have supervision then at
24 that time I don't think before I became, before I
25 trained as a behavioural therapist. There wasn't 14:58
26 generally supervision, I don't think at that time. I
27 think they would have just been, I don't remember that
28 ever when I was nursing.

29 59 Q. MS. BRIGGS: You describe in detail in your statement

1 about physical injuries you sustained, assaults or
2 threats that you received from patients while you were
3 working at Muckamore. You actually say in your
4 statement you were injured you think hundreds of times.
5 Did you regard injuries as inevitable given the 14:59
6 environment that you worked in or was there more that
7 could have been done by other staff or management to
8 ensure your safety?

9 A. I think it was difficult because I was constantly I
10 suppose in the frontline and everybody I worked with 14:59
11 had challenging behaviour and were presenting with
12 behaviour difficulties, so when you were there and you
13 were working with them, you were the person there
14 directly with that person, you were going to get those
15 injuries, you were going to get -- it was, I mean none 14:59
16 of the children, there were very few of them ever that
17 it was a deliberate attempt to harm you. A lot of it
18 was to do with their communication. A lot of it was to
19 do with they had a history. One of the difficulties,
20 if you are working with a young teenager who has a long 15:00
21 history of using their behaviour to effectively
22 maintain their environment and to get their needs met
23 and that behaviour has got a long history, it is really
24 hard to change that kind of behaviour. But you can't
25 change the behaviour without building a relationship 15:00
26 with that person. You have to build that relationship,
27 you have to have confidence with them, they have to
28 have confidence with you. So have to be in direct
29 contact with them and a lot of the times you are

1 putting yourself in the firing line because you are
2 going to get the behaviour and sometimes you just
3 accept it.

4 60 Q. Hindsight is a wonderful thing, but looking back now do
5 you think there is anything that could have been done 15:00
6 by those above you to help protect you physically from
7 that type of harm?

8 A. I think in the early days we never had alarm systems or
9 anything so we couldn't have had anybody to call on.
10 So you didn't always have that kind of back up support. 15:01
11 We didn't have any specific training in physical
12 intervention so if you have a big 16 year old fella
13 coming to attack you, we didn't have, you weren't
14 taught anything of how to actually get out of that or
15 how to manage that or how to restrain that person. And 15:01
16 I know there's a lot around the sort of MAPA training,
17 sometimes it was necessary and you had to feel
18 confident in whenever you're faced with somebody that's
19 going to actually attack you and going to injure you,
20 you have to feel confident in how you can manage that 15:01
21 and that person.

22 61 Q. DR. MAXWELL: So I understand what you're saying, it's
23 difficult to prevent this?

24 A. Yes.

25 62 Q. DR. MAXWELL: And that the patients did not intend to 15:02
26 harm you, but some of the injuries you had sound quite
27 serious and what sort of support did the Trust give you
28 after you had been injured, because it must have been
29 very frightening as well as physically painful?

1 A. We didn't really get any support.

2 63 Q. DR. MAXWELL: And so that could be quite challenging
3 for staff if they had been injured, even if they
4 understood the patient didn't mean to do it and they
5 weren't getting support, they presumably quite fearful 15:02
6 of being injured again, some staff?

7 A. It was. They just didn't seem to be that -- I don't
8 know, in many ways I think people just accepted it and
9 felt it was part of our job. So we didn't really get
10 -- there were, on a few occasions, I can remember one 15:02
11 of the senior nurse managers being fairly concerned
12 after I had an eye injury and he had to take me to the
13 hospital and he was really concerned just at the level
14 of abuse that I was taking. But, as far as anything
15 specific happening about it, there really wasn't 15:03
16 anything.

17 64 Q. DR. MAXWELL: There wasn't any debriefing, because we
18 now have a system where if there has been an incident
19 there is quite often a debriefing session?

20 A. No. 15:03

21 65 Q. DR. MAXWELL: Nothing like that?

22 66 Q. CHAIRPERSON: Can I just pick up on that, you explained
23 in your evidence how you once had a fire extinguisher
24 thrown at you?

25 A. Yes. 15:03

26 67 Q. CHAIRPERSON: So what happened, it was very shocking
27 for you, it could have done you a lot of harm?

28 A. It was very shocking. When I say I sat down, I
29 actually had to run to the ladies toilet and sit down

1 there and cry my eyes out for a couple of hours.

2 68 Q. CHAIRPERSON: was there any investigation around that?

3 A. No.

4 CHAIRPERSON: And what had happened.

5 A. No. 15:03

6 69 Q. CHAIRPERSON: But you did report it?

7 A. Yes, it was reported and I mean it was so, it was

8 actually when the fire extinguisher hit the floor in

9 front of me, they actually had to put a big patch on

10 the floor because it actually broke right through the 15:04

11 covering that was on the floor. And it was quite a

12 shocking incident, had the fire extinguish hit me I

13 probably wouldn't be here.

14 70 Q. CHAIRPERSON: Can you remember when that was?

15 A. That was in the Iveagh Centre. That was, I can't 15:04

16 remember the exact year. I'm retired seven years.

17 It's about 10, 12 years ago.

18 71 Q. CHAIRPERSON: Right but as far as you know there was no

19 investigation of that?

20 A. No. 15:04

21 72 Q. CHAIRPERSON: And you were offered no support?

22 A. No.

23 CHAIRPERSON: Thank you.

24 73 Q. MS. BRIGGS: Christine, you also say that when you were

25 injured that most of the time accident report forms 15:04

26 weren't filled out because you say it would have taken

27 too long and you do say that you filled out those forms

28 when your injuries were more significant?

29 A. Yes.

1 74 Q. what about other staff, did they kind of follow the
2 same rules that you did in that regard?
3 A. I think a lot of times, you take it like if somebody
4 just slapped you or hit you, you know, if you have to
5 fill in an accident form for that there would have been 15:05
6 so much. But whenever somebody really injured you or
7 hurt you, you would have filled in an accident form. I
8 suppose it's, I think maybe it becomes acceptable.

9 75 Q. And was that acceptance or tolerance of those kind of
10 lower level injuries, you've given the example of a 15:05
11 slap, was that something those in management supported?
12 A. I don't know that management particularly supported it.
13 I think that it was one of those things that when
14 you're working with learning disability, you are
15 working with the people, the children, you had a 15:05
16 relationship with them and you don't, I suppose you
17 didn't -- you didn't want to make them be seen in a bad
18 way, you know. You didn't want them to be actually
19 targeted all the time or saying negative things about
20 them and that can be quite difficult. 15:06

21 76 Q. DR. MAXWELL: Management may not have been happy with
22 it but --
23 A. Sorry. I can't hear you.

24 77 Q. DR. MAXWELL: Sorry, management may not have been happy
25 with that but do you think they understood that there 15:06
26 was under reporting?
27 A. I don't think so, no. I think it was just, I don't
28 know, I don't think the patients ever thought about
29 whether we filled in forms.

1 78 Q. DR. MAXWELL: No, the management side?
2 A. The management.

3 79 Q. DR. MAXWELL: The 8As, would they have understood that
4 there were a number of assaults on staff?
5 A. Yes, that there were some at low level that didn't get 15:06
6 recorded.

7 80 Q. DR. MAXWELL: So the 8As would have known that was
8 happening but not being reported on incident forms?
9 A. Yes.

10 CHAIRPERSON: I am just thinking, the witness has been 15:07
11 there about an hour, would it be sensible to take a
12 short break?

13 MS. BRIGGS: I spoke to the witness before and she had
14 indicated she would like to keep going if possible, but
15 we said we would keep it under review. Christine, 15:07
16 we'll leave it in your hands and also the hands of the
17 Panel and stenographer might need a break as well,
18 Chair.

19 CHAIRPERSON: I think we should take a short break.
20 A. Okay. 15:07

21 CHAIRPERSON: I think just for 10 minutes. I think it
22 is a long time for anybody to focus, but also for the
23 stenographer who is working almost as hard as you are.
24 All right. So can we just take 10 minutes please and
25 then we'll be back. 15:07
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27 THE HEARING ADJOURNED FOR A SHORT PERIOD

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29 THE HEARING RESUMED AS FOLLOWS:

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CHAIRPERSON: Thank you.

81 Q. MS. BRIGGS: Christine, I'm going to move on to something else now, okay, you raised in your statement that you had raised issues around the food at Muckamore 15:19
okay?

A. Sorry?

82 Q. You had raised in your statement and you said in your statement --

A. About the food. 15:19

83 Q. That you had raised issues about the food at Muckamore?

A. Yes.

84 Q. And you say that when you raised your concerns about the food you got into trouble and you say you were asked to apologise? 15:19

A. Yeah.

85 Q. When was that roughly, can you say?

A. That was, gosh that must have been about, about 2008 or that. And it was around the time, Muckamore used to have its own kitchens and all the food was sort of made 15:20
there and it was always fresh food. Then things changed, the kitchens were closed down, food was being brought in so they were bringing food in. I think at that time it was coming in from Scotland. It was being brought in. We had our own caterer in the children's 15:20
ward that worked in the kitchens and he would have, he would have cooked the food but he would have always added extra bits to it. If it was pizzas he would have put on more tomatoes and things like that, just dressed

1 things up and made it really nice. Then they took
2 [name] away from the kitchens and the food was coming
3 in and it was cooked in another ward and put in a
4 heated trolley and then brought to our children's ward
5 and sat there, so it could have sat for an hour before 15:21
6 it was served out to the children. So I would have
7 brought the children over to the ward for their meal.
8 It just didn't look very appetising, it didn't look
9 very good. Because I was always trying to -- because I
10 worked in behavioural work, you are trying to encourage 15:21
11 healthy eating and good food, no additives, no
12 colourants and things like that, because a lot of those
13 things affected their behaviours. So I did complain
14 about it and, the fella in charge, I can't remember his
15 name, was in charge of the catering, he wasn't very 15:21
16 happy with me and I was asked to apologise to him. I
17 said I really couldn't apologise because my mind hadn't
18 changed, the food wasn't acceptable so I wasn't happy
19 with it. It was discussed and, to be fair [named] the
20 Director of Nursing Services at the time. 15:21
21 CHAIRPERSON: we will stop there.
22 MS. BRIGGS: It happens all the time. we'll pause the
23 feed now?
24 CHAIRPERSON: And get the cipher number.
25 MS. BRIGGS: You were about to carry on in respect of 15:22
26 the food and the issues you had raised in respect of
27 the food, if you pick it up there with what you were
28 going to say.
29 A. Yes, when we raised it then, I raised it with H359, she

1 then started a working party. So there was a group set
2 up then to look at the diets and the food and to bring
3 in more healthy eating and exercise as well was brought
4 in.

5 86 Q. CHAIRPERSON: And did it change the food? 15:22

6 A. It changed the food, yes, slightly. But the food was
7 still being brought in because we had lost our
8 kitchens, but the food was being brought in so they
9 tried then to get it into a more healthy diet for the
10 children particularly. 15:23

11 CHAIRPERSON: I'm sorry, Dr. Maxwell.

12 87 Q. DR. MAXWELL: Can I just ask you, using the cipher
13 number, who was it that asked you to apologise for your
14 comments in the first place?

15 A. H359. 15:23

16 DR. MAXWELL: Right.

17 88 Q. CHAIRPERSON: And who were you meant to apologise to?

18 A. The head of the Catering Department at Muckamore.

19 89 Q. DR. MAXWELL: And when you were asked to apologise, did
20 you think that was unusual or was there a general 15:23
21 culture of we don't really complain about things?

22 A. I think it was they didn't want to upset the --
23 because.

24 90 Q. DR. MAXWELL: The individual?

25 A. They didn't want to upset him because I had challenged 15:23
26 him about the diet, about the food, and maybe they felt
27 that I was being maybe out of order in doing that.

28 91 Q. DR. MAXWELL: So if you had had occasion to suggest
29 some other things that could be improved, do you think

1 that that would have been well received?
2 A. Generally it was, yes. Generally things that I would
3 have looked at when we -- I know certainly that when we
4 introduced exercise programs, we introduced the circle
5 time with the positive movements and things like that, 15:24
6 they were all well received and sort of promoted and
7 whenever I would have looked at things like when I
8 wanted to introduce the PECS communication system with
9 the children as well, when I could give a rationale for
10 that, they were quite happy. They could see what it 15:24
11 was doing, what was the end result of that. It was the
12 same whenever I went to train as a family therapist to
13 do some family work, because I was involved so much
14 with families and I wanted to go on the course and when
15 I approached management about it, initially they 15:24
16 weren't going to release me for it but then when they
17 looked at it they felt yes, it was good and supported
18 me in doing that and actually funded that as well,
19 which was good.
20 DR. MAXWELL: Thank you. 15:25
21 92 Q. MS. BRIGGS: what about specific concerns, you have
22 given the example of wanting to bring in the PECS
23 system, the Picture Exchange Communication System but
24 what about other times when you had something negative
25 to say about Muckamore? were there other times other 15:25
26 than the food that you can recall making a negative
27 comment or a suggestion about something that wasn't
28 quite up to standard and how was that received?
29 A. Generally things that when we would have brought them

1 up, particularly when we had team meetings, we had a
2 team meeting and you brought up concerns, they normally
3 were always looked at and sort of addressed.

4 93 Q. What type of concerns might you have raised?

5 A. I'm trying to think now about concerns that I would 15:25
6 have had. I think sometimes things around the
7 resources that were available to us, particularly with
8 children and the range of activities that we could
9 have. We didn't always have -- as Muckamore became
10 more going along the lines of being a specialist 15:26
11 hospital, the children were being, we were being pushed
12 out and that was quite a concern because we were, we
13 didn't have access to some of the facilities at the
14 hospital, we didn't have access down to the gardens in
15 the same way because there were adults there and the 15:26
16 children weren't allowed to be where the adults were.
17 But it felt as if we were actually being penalised
18 because we were there. And, you know, we were just
19 seen as being problematic that we were there within
20 this adult environment which really wasn't our doing. 15:26
21 So we had a bit of a, sort of to stand up for ourselves
22 a wee bit and the children, until they moved us we had
23 the right to be there.

24 94 Q. When you raised that issue was that dealt with, was the
25 issue resolved? 15:27

26 A. Well it was only resolved when actually we moved out of
27 the hospital and we had to take the children out of the
28 hospital, we were moved from there. So we always had
29 to plan everything about what we were doing with the

1 children. Like if I wanted to use the Social Training
2 Centre in the evening time, if I wanted to use the
3 kitchens or the gym or anything I had to make sure that
4 there were no adults in that building at the same time.
5 It got then that we had to be careful of where we were 15:27
6 walking the children because of Six Mile, because it
7 was a forensic unit, I couldn't take the children down
8 past that area. So things became difficult then until
9 we moved out.

10 95 Q. I am going to move on at this stage and ask you about 15:27
11 supervision, okay. At paragraph 13 of your statement
12 you talk about a patient?

13 CHAIRPERSON: Keep your voice up, Ms. Briggs, sorry.

14 96 Q. MS. BRIGGS: Sorry, at paragraph 13 of your statement
15 you talk about a patient okay, it's at page 5, all 15:28
16 right. The patient has been given the cipher P11. You
17 say at paragraph 13 there that you were asked to
18 special him?

19 A. Yes.

20 97 Q. Meaning that he required additional nursing care and 15:28
21 supervision?

22 A. Yes.

23 98 Q. Was that phrase "specialing" or being "specialled", was
24 that used among staff generally?

25 A. Yes, special, that meant you were actually on a one to 15:28
26 one with that child or that person so you would have
27 been with them at all times, they had to be within
28 arm's length or within your view at all times and you
29 had to, you couldn't move away until somebody else came

1 to take over to so that they could move away.

2 99 Q. So on each shift then would there be one staff member
3 who was specialied with the child in question?

4 A. Yes, but it might have changed, depending on how
5 difficult the child was to manage, that person, that 15:28
6 might have changed or rotated if it was decided maybe
7 that somebody could only cope with that behaviour for a
8 half an hour period of time, so there would have been a
9 rolling basis where they swapped over.

10 100 Q. Could there have been a scenario where one staff member 15:29
11 was specialing with a child the whole day and how would
12 things like breaks be facilitated in that way or would
13 it always have been swapped around?

14 A. Sometimes there were people that were on a special and
15 you might have been on that special for a whole shift, 15:29
16 now that would never have happened, I wouldn't have
17 been in that position once I moved on as a therapist.
18 But, if somebody was on for the full shift there would
19 always have been somebody that would have come to take
20 over for break times and for lunch times and things 15:29
21 like that, so that would have swapped over at that
22 particular time. But I would not have been in that
23 position.

24 101 Q. And who would have decided that a particular patient
25 needed to be specialied, who made that decision? 15:29

26 A. Generally the multidisciplinary team but mostly the
27 consultant.

28 102 Q. And if I digress for a moment from the topic of
29 supervision, you mention P11 injuring himself, you say

1 that he punched his own face and his eyes?

2 A. Yes.

3 103 Q. How were self injuries like that recorded by nursing
4 staff?

5 A. They would have been recorded in just as being, unless 15:30
6 we were doing a function analysis, we would record how
7 many times they would have hit in that period of time
8 but the self-injurious behaviour would have been
9 recorded, the person was being self-injurious during
10 that period of time with multiple punches. With that 15:30
11 particular child it was very hard to, unless you were
12 watching the whole time and somebody counting, because
13 somebody else had to be blocking him the whole time.
14 If you let go of his hands or weren't blocking him he
15 would have got in the punches either to his chin or to 15:30
16 his eyes.

17 104 Q. But the expectation was that each time a particular
18 patient engaged in that type of behaviour, that it
19 would be recorded by nursing staff?

20 A. Yes. 15:30

21 105 Q. DR. MAXWELL: would that be recorded in the nursing
22 notes or on the Datix?

23 A. They would have been recorded in the patient's notes.

24 106 Q. DR. MAXWELL: But not on Datix?

25 A. Not in? 15:31

26 107 Q. DR. MAXWELL: On the instant reporting system?

27 A. I think, yes, it should have been reported on the
28 incident reporting system.

29 108 Q. DR. MAXWELL: You have told us that sometimes the staff

1 didn't fill in the instant reports because they take a
2 long time to fill in?

3 A. They wouldn't have filled it for themselves but
4 certainly if it was for a patient injuring themselves,
5 they would always have been reported. 15:31

6 109 Q. DR. MAXWELL: You think that would always have been
7 filled in for patients?

8 A. They would always have been reported, yes.

9 110 Q. MS. BRIGGS: Christine, I am going to ask you about the
10 personal care of patients so things like washing, 15:31
11 dressing, dental care, that type of thing. Was there
12 any aspect of physical care like dental care or
13 personal hygiene that was more difficult than others,
14 can you speak to that from your experience of working
15 in the wards, way back when? 15:31

16 A. When we worked in the wards in around about the 70s and
17 80s, there were big wards, and great big bathrooms and
18 things like that. It says there ten patients, there
19 weren't ten patients in the bathroom at the time.

20 CHAIRPERSON: Can you just slow down a little bit, 15:32
21 sorry.

22 A. Sorry, there weren't ten patients in the bathroom at
23 the one time but there would have been only maybe two
24 bathrooms in the whole building. So somebody would be
25 bathed, they would be taken out of the bath and then 15:32
26 somebody else would come into the bathroom. But with
27 the new wards, they had en suites built on to them, so
28 they had individual showers put in the wards.

29 111 Q. And do you know what those later nursing staff did, the

1 ones that came after you, what would they have done if
2 a patient declined, for example, a wash that day, do
3 you know what the procedure would have been in that
4 situation? And if you can't speak to it, Christine,
5 you don't have to, you can say you don't know, okay? 15:32

6 A. Because I wasn't working in the wards, I really
7 wouldn't have been aware, but I know certainly in the
8 children's ward in the Iveagh Centre, all the children
9 would have had a shower nearly every morning or a bath
10 if they preferred it, just some of them, their personal 15:33
11 choice, you know.

12 112 Q. DR. MAXWELL: But if they declined?

13 A. Pardon?

14 113 Q. DR. MAXWELL: If a child in the Iveagh Centre said 'I
15 don't want a bath today' but the nurse felt, well 15:33
16 actually, you need one?

17 A. They would probably have offered them to maybe just
18 have a body wash if they didn't really want, they would
19 have encouraged them.

20 114 Q. DR. MAXWELL: If they really, really declined, would 15:33
21 the nurses have to respect that?

22 A. I think, yes, they would have respected it, but it was
23 very rarely that children ever did. Most of them, the
24 children liked having a bath, they liked playing in the
25 bath. 15:33

26 115 Q. DR. MAXWELL: we have heard evidence that a lot of
27 people didn't get good dental hygiene, if there were
28 concerns that somebody was not getting, was not
29 complying with good dental care, what would the nurses

1 do?

2 A. If they weren't complying with the dental care, let me
3 think of it there, normally we would have maybe used,
4 because that would have been seen maybe as a
5 behavioural issue. I know that one child we worked 15:34
6 with, going back quite a number of years ago in
7 Muckamore, in the children's ward, and we actually
8 worked with the First and Then system that we worked
9 with them, they actually learned how to clean their
10 teeth as part of their work system where they, first 15:34
11 this and then that. We had to teach them how to clean
12 their teeth and then they got their reward at the end
13 of that. So there were times when we would have used a
14 behaviour support plan to help them with personal care
15 because it is very important. 15:34

16 116 Q. DR. MAXWELL: As an experienced professional nurse,
17 would you expect a nurse to record if a patient
18 consistently refused to have personal hygiene care?

19 A. Yes, they would.

20 117 Q. DR. MAXWELL: You would expect them to put that as a 15:34
21 problem in their records?

22 A. It would be expected to report that on and issue that
23 into their care plan.

24 DR. MAXWELL: Thank you.

25 118 Q. MS. BRIGGS: Christine, I want to ask you about the use 15:35
26 of sedation and PRN, okay. You talk about that in your
27 statement and you describe how you didn't have input
28 into the actual use of PRN?

29 A. No.

- 1 119 Q. But you would look at its use after the event and see
2 whether there was anything to learn from the use of
3 PRN?
- 4 A. Yes.
- 5 120 Q. Who was responsible for actually making the decision on 15:35
6 the ground to administer PRN in the first place?
- 7 A. Well the PRN would have been prescribed by the
8 consultant, but the issue of when to administer the PRN
9 would have been done by the nurse that was in charge of
10 the ward at the time. 15:35
- 11 121 Q. Did you look at or review all of the instances when PRN
12 was used?
- 13 A. No, no.
- 14 122 Q. What brought about you conducting a review, when would
15 that have taken place? 15:35
- 16 A. If we were looking at, when we would have had the team
17 meeting, we normally had them on a Thursday, we would
18 have looked at the use of PRN maybe if it had been used
19 and what was the impact of that PRN, whether it was
20 effective or non-effective. 15:36
- 21 123 Q. But you would expect to be made aware at that team
22 meeting of every use of PRN or is that not accurate?
- 23 A. If PRN was used it was always brought up at the
24 children's review meeting so it was always brought up
25 on a weekly basis if PRN was used. 15:36
- 26 124 Q. When you conducted your exercise of looking back at its
27 use, what reasons were provided for the use of PRN
28 typically?
- 29 A. Well PRN would be used as prescribed for the behaviour

1 that was documented. So if a child was particularly
2 aggressive or very disruptive or very agitated, PRN
3 might have been used then.

4 125 Q. And did the reasons for the use of PRN ever change over
5 time or did they roughly remain the same, it was in 15:36
6 response to a behavioural issue?

7 A. If behaviour, if you put in a behaviour support plan
8 and once it starts to work and once the programme would
9 hopefully be working, PRN should become non-effective.

10 126 Q. Should become not effective at all? 15:37

11 A. Not be used.

12 127 Q. Not be administered?

13 A. You always hope to reduce the use of it.

14 128 Q. And did you see success with that?

15 A. Yes. 15:37

16 129 Q. Or were there certain patients where PRN had to keep
17 being used, notwithstanding the fact there was a
18 behavioural plan in place?

19 A. In most instances PRN, you didn't really want to have
20 PRN being used out in the community so you really 15:37
21 didn't want a child, if a child was going back to
22 school and back into a classroom or back home again,
23 you didn't want them going back having to be on PRN
24 because it meant their behaviour was not being managed
25 properly or being managed appropriately. 15:37

26 130 Q. So you refer in your statement to deescalation
27 techniques?

28 A. Yes.

29 131 Q. Can I take it from your evidence then that the aim was

1 to decrease the use of PRN while increasing the use of
2 those diversionary kind of techniques?

3 A. Yes.

4 132 Q. Did that occur with all patients or were there simply
5 some patients where PRN was necessary throughout the
6 time at Muckamore? 15:38

7 A. Mostly, well any of our children that we were moving on
8 and going out to school, that we were using
9 redirection and deescalation and all of those things,
10 the behaviour support plan would have been effective 15:38
11 before we would have moved them on. PRN was only ever
12 used I think long-term with some children who were very
13 self-injurious and that's -- very serious
14 self-injurious behaviour is one of the most difficult
15 behaviours to change or turn it about and they could 15:38
16 continually be on PRN, continually.

17 133 Q. The Inquiry has heard evidence about abuse suffered by
18 patients at Muckamore and abuse is defined widely in
19 that sense, physical abuse or sexual abuse or financial
20 abuse or neglect or things like interference with 15:39
21 belongings. You say in your statement that you
22 wouldn't have stayed at Muckamore if you saw patients
23 being abused?

24 A. I definitely wouldn't, and it's something that I had
25 not experienced and certainly it was something that if 15:39
26 I ever felt if I had seen any kind of level of abuse or
27 that, I would have certainly spoke up about it. I've
28 never been known for being quiet about what would
29 bother me. So if something that I felt was untoward I

1 certainly would speak up about it.

2 134 Q. what about neglect, did you ever see anything like
3 that?

4 A. No.

5 135 Q. Because you say in your statement you don't think you 15:39
6 saw neglect?

7 A. No.

8 136 Q. You never saw neglect?

9 A. No.

10 137 Q. Okay. I want to ask you about some changes you say 15:39
11 that you saw to Muckamore during your time there and
12 you've provided at paragraph 25 of your statement a
13 long list of the types of activities that patients did.
14 You refer to walks, film clubs, playing pool, that kind
15 of thing and you say that ultimately they were removed, 15:40
16 okay?

17 A. Yes.

18 138 Q. When did the removal of those activities take place?

19 A. When Muckamore went through that period of change when
20 they decided that it was going to become a specialist 15:40
21 hospital. It was to become a hospital and we had to go
22 back to calling them patients. We had gone through all
23 those periods of changes with learning disability from
24 when I started there in the 70s, there were different
25 changes come along. Firstly they were patients. First 15:40
26 it was mental handicap, then it was not allowed to be
27 mental handicap, then it was learning disability, then
28 it was learning difficulty. First it was patients,
29 then it was clients, then it was residents, then back

1 to patients again. So it just seemed to swing by
2 whatever the people up here decided these changes would
3 be made. The hospital was a really big large hospital
4 with lovely grounds. There is lots of activities that
5 took place in it. It was a very homely, friendly 15:41
6 atmosphere about the hospital then. The nurses trained
7 there, we all lived in nurses' homes it was just a very
8 -- quite community minded. The activities, Muckamore
9 going back in the 70s, the 80s had its own radio
10 station that the patients were fully involved in. You 15:41
11 could have put requests on or gone down and sat with
12 [name].

13 139 Q. We will just stop a wee second. There was a name used.
14 We'll just pause for a moment?

15 A. Right, yes, sorry. 15:41

16 CHAIRPERSON: We're not too worried about the disc
17 jockey are we?

18 140 Q. MS. BRIGGS: Fine, all right. We'll not pause then and
19 we'll keep going, sorry to interrupt you Christine?

20 A. It was always very, the activities, if you had gone 15:41
21 around the grounds then you would have always seen
22 patients out walking, out with staff, out doing things,
23 having picnics in the grounds. We would have taken the
24 children away down by F7, away down there and spent a
25 couple of hours down there playing games. They had 15:42
26 cinema on a Friday night, they had church, they had
27 chapel, they had discos, parties, their own snooker
28 team, ladies dance groups, football teams, everything.

29 141 Q. You referred, Christine, to the 70s and 80s when it was

1 like that?

2 A. 70s, 80s, 90s.

3 142 Q. It is the 90s onwards that you are talking about these
4 changes taking place?

5 A. Right up until they started to build the new part of 15:42
6 the hospital, all those activities were taken away and
7 they knocked down the recreational hall. The big
8 recreational hall was the heart of Muckamore. It was
9 this big centre that everybody used and the big stage
10 on, they had pantomimes, they had drama groups, 15:42
11 everything was going there. They took that all away.
12 They knocked it down. Everything had to stop. There's
13 nowhere to walk now because they have fenced off all
14 the grounds, so there only just this wee nuclear in the
15 middle. You take away activities. When our people 15:43
16 with learning disabilities, a lot of their problems are
17 social problems. A lot of their problems are
18 communication. A lot of their problems are around
19 being accepted. When they were in Muckamore, they were
20 accepted. They were, the hospital at that time, nobody 15:43
21 ever -- they seen them walking around the grounds and
22 they were making strange noises or doing what other
23 people would class as unacceptable behaviour, nobody
24 challenged it, nobody thought anything of it, they went
25 and supported them and looked after them. All of those 15:43
26 things started to change. When staff have nothing --
27 when they have no activities for the staff to do with
28 the patients, when they have nothing to do with them,
29 when they can't take them swimming or when they can't

1 take them to the cinema, when they can't take them --
2 what do they do?

3 143 Q. what about, Christine, when you left Muckamore in 2010
4 what kind of activities were available to patients at
5 that time? 15:44

6 A. When I left Muckamore?

7 144 Q. Yes?

8 A. All those activities were gone. When I left they
9 started, when Six Mile was built and the other wards,
10 Cranfield and all were built, all those activities had 15:44
11 to stop.

12 145 Q. Was there anything left for patients by way of
13 recreational activity?

14 A. Because they were seen as patients in a hospital, and
15 patients don't play snooker, patients don't do this, it 15:44
16 was said if you want to play snooker go out to the
17 community and do it so all of those activities are
18 gone.

19 146 Q. And there was nothing left for patients, is that what
20 your evidence is? 15:44

21 A. No, they go to daycare and they go down to daycare and
22 they just do small activities in daycare but they
23 certainly don't have their cinema or discos, where they
24 socialised and interacted and learned all those skills,
25 that's all been taken from them. 15:44

26 147 Q. Was that because there was a change in the philosophy
27 of care, or why did that happen, why were those
28 activities taken away from patients, can you understand
29 that?

1 A. I can't understand it and I think the majority of staff
2 at Muckamore couldn't understand it. We didn't have a
3 big say in the decision making of it. Those decisions
4 were made away above our head.

5 148 Q. Was any justification provided, or could you have asked 15:45
6 for a justification?

7 A. They were just termed that now it was a specialist
8 hospital and they were patients and they were to be
9 treated as patients.

10 149 Q. DR. MAXWELL: What would you have called it before this 15:45
11 change to call it a specialist hospital?

12 A. What did I?

13 150 Q. DR. MAXWELL: How did people refer to it before it came
14 this new specialist hospital?

15 A. It was just The Abbey. 15:45

16 151 Q. DR. MAXWELL: It was just called The Abbey?

17 A. The Abbey.

18 152 Q. DR. MAXWELL: You were working there, did you think of
19 it as a hospital or did you think of it as a community
20 or did you think of it as a home? 15:45

21 A. More of a community. It was, at that stage, going
22 through, and I think a lot of the nurses felt that it
23 should have become more of a community setting. It
24 should have been a community where our people with
25 learning disability could live happily and quite 15:46
26 contentedly within that environment.

27 153 Q. DR. MAXWELL: So if it became a specialist hospital did
28 that mean that this was now more about medical
29 treatment, because you talked earlier about a lot of

1 the people's issues were around social activity?

2 A. Yes.

3 154 Q. DR. MAXWELL: If it became a specialist hospital did
4 this now become somewhere for medical treatment?

5 A. It seems to be more about treatment, but certainly 15:46
6 because I had moved away then, we were in the Iveagh
7 Centre, so we had moved out of the hospital. We were
8 able to organise our own activities and things with our
9 children. But I think within the hospital setting it
10 was more seen as treatment that people that were there 15:46
11 were patients and they were there to be treated and
12 not, it wasn't social.

13 155 Q. And how long before you moved to the Iveagh Centre did
14 this change to a specialist hospital happen?

15 A. It was already starting before these wards were being 15:47
16 built and it was already starting then where activities
17 were sort of being stopped, you know, like the sort of
18 cinema and that. The recreational hall was knocked
19 down after I had left.

20 156 Q. DR. MAXWELL: So the change started at the same time 15:47
21 they decided to build new wards?

22 A. Yes.

23 157 Q. MS. BRIGGS: All right, Christine, the final two topics
24 I am going to ask you about are seclusion and
25 restraint, okay. If we start with seclusion, all 15:47
26 right. You mention one patient in particular, it's
27 P34, it's at page 12, paragraph 32 of your statement if
28 you want to go and refresh your memory. It's P34 we're
29 talking about, and you describe them as someone on whom

1 seclusion would not have worked?

2 A. Right.

3 158 Q. In what circumstances and on what sort of patient would
4 seclusion have been helpful?

5 A. Particularly with patients that maybe, that suffered 15:48
6 from autism, that maybe had to be, that physical
7 intervention certainly wasn't helpful with them. If
8 somebody that had a difficulty with people in their
9 close proximity or people holding them, that it wasn't
10 helpful for them and could maybe make the behaviour 15:48
11 escalate, they can become more agitated. So to go into
12 a seclusion room where they could bring themselves down
13 was positive for them.

14 159 Q. And who made the decision whether or not seclusion
15 should be used on an individual patient, was it left to 15:48
16 nursing staff on the ward to exercise discretion or
17 were those kind of decisions made at a higher level?

18 A. It was normally, I think in the sort of adult side it
19 would probably have been in their care plan.

20 160 Q. You would have expected then to see some sort of 15:48
21 reference to seclusion in the care plan that would have
22 said whether it's a helpful or unhelpful intervention
23 for that patient?

24 A. Yes, yes.

25 161 Q. DR. MAXWELL: But then, the timing of it, so if the 15:49
26 care plan said that seclusion might be a helpful
27 intervention?

28 A. Yes.

29 162 Q. DR. MAXWELL: who then made the decision about enacting

1 that care plan?

2 A. In?

3 163 Q. DR. MAXWELL: who would make the decision to use that,
4 would that be the nurse in charge of the ward, would
5 they have to call a doctor? 15:49

6 A. It would be within the multidisciplinary team and
7 probably with the ward staff. Sometimes seclusion
8 would have been used, it would have had to be used in
9 an emergency situation. If somebody came and was quite
10 violent or attacking, seclusion would have to be used 15:49
11 in an emergency situation like that. But always, any
12 time that I seen seclusion used it was always for the
13 shortest time possible until the person actually
14 settled down. And they were always -- it was always
15 documented and there was always somebody that viewed 15:50
16 them all the time, so they were viewed all the time
17 they were in that seclusion.

18 164 Q. DR. MAXWELL: In an emergency situation, if seclusion
19 wasn't included on the care plan, would it be
20 appropriate in an emergency for the nurse in charge to 15:50
21 decide to seclude somebody?

22 A. Yes.

23 165 Q. DR. MAXWELL: It would?

24 A. Yes.

25 166 Q. DR. MAXWELL: But obviously then recorded and 15:50
26 discussed with the MDT?

27 A. Yes, it always had to be recorded, yes.

28 167 Q. CHAIRPERSON: And can I just pick up on what you were
29 just saying about somebody being there all the time?

1 A. Yes.

2 168 Q. CHAIRPERSON: To be able to see the person who was in
3 seclusion?

4 A. Yes, yes.

5 169 Q. CHAIRPERSON: what's your basis for saying that, is 15:50
6 that because that was what was meant to happen or did
7 you see that happening?

8 A. Well I seen that happening with somebody, they would
9 view, they would always watch the child and that was
10 recorded every 15 minutes that that was recorded, that 15:50
11 that child or that person had been watched.

12 170 Q. CHAIRPERSON: And was seclusion used for children?

13 A. Pardon?

14 171 Q. CHAIRPERSON: was seclusion used for children?

15 A. In some cases, yes. 15:51

16 172 Q. CHAIRPERSON: Right?

17 A. Not with very young children but sometimes with the
18 teenagers, yes.

19 173 Q. DR. MAXWELL: Can I just ask...

20 MS. BRIGGS: Go ahead Dr. Maxwell. 15:51

21 174 Q. DR. MAXWELL...you say it had to be recorded, was there
22 a central register of all the incidents of seclusion,
23 or was it just recorded in the patient's notes?

24 A. It was recorded in the notes, but if seclusion was used
25 and the person had to be taken to seclusion and they 15:51
26 had used physical intervention to take them to
27 seclusion, that always was recorded, that always had to
28 be recorded on a sheet and they would have had a
29 recording sheet where you had to record what hold you

1 used and how long for and everything else, that would
2 be recorded. And the person that was maybe in
3 seclusion, that was recorded and for the length of time
4 they were in seclusion and then what happened then
5 afterwards. 15:52

6 175 Q. DR. MAXWELL: That was all in the patient's record
7 rather than in some other ward-based register?

8 A. Yes, it should have gone into then a central register
9 as well.

10 176 Q. DR. MAXWELL: There was a central register? 15:52

11 A. Yes, I think so.

12 177 Q. DR. MAXWELL: was that only when restraint was used?
13 So if you suggested to a patient that seclusion would
14 be helpful for them?

15 A. Yes. 15:52

16 178 Q. DR. MAXWELL: And they went into the room without any
17 assistance, would that go on to a central register?

18 A. That would be registered as well, yes, if they went
19 into seclusion. If they went into seclusion themselves
20 because sometimes -- 15:52

21 179 Q. DR. MAXWELL: we have heard some people asked for it.
22 A. ... would go into seclusion themselves. I think that
23 would just go into their care plan. I don't know
24 whether they would have filled in like a recording
25 sheet for that. 15:52

26 180 Q. DR. MAXWELL: You think that if we were to ask for the
27 ward register of seclusion incidents, there should be a
28 document?

29 A. It should be in the person's care plan, yes.

1 181 Q. DR. MAXWELL: would there also be a separate register?
2 You know how in the olden days, you and I would
3 remember the bath book and things like that, would
4 there have been a central record like that?
5 A. I know there was a central register for all the 15:53
6 physical intervention.
7 182 Q. DR. MAXWELL: Restraint but not necessarily seclusion?
8 A. I'm not sure if there was one for that kind of
9 seclusion, I'm not so sure.
10 183 Q. MS. BRIGGS: Okay. You were touching there on the use 15:53
11 of seclusion on children's wards when the Chair was
12 asking you a question. You say in your statement that
13 there weren't seclusion rooms on the children's ward?
14 A. Yeah.
15 184 Q. So how was seclusion carried out in the absence of a 15:53
16 seclusion room?
17 A. There was no seclusion room when we were in Conicar but
18 we would have taken the child maybe, if they were in
19 the main day room we would have taken out into another
20 room, the dining room or the kitchen or out to the 15:53
21 garden or somewhere else, but they weren't in any
22 seclusion. There was a seclusion room in the Iveagh
23 Centre, a specific seclusion room.
24 185 Q. And turning back to Conicar, do you know after you left
25 that, being on the ward yourself, whether a seclusion 15:54
26 room was ever introduced there?
27 A. No.
28 186 Q. It was never introduced?
29 A. They never had a separate seclusion room.

1 187 Q. Okay. And then on the topic of restraint, which we've
2 touched on a little bit, I just want to be clear about
3 your evidence, okay. When you talk about restraint in
4 your statement you refer to using diversionary
5 strategies rather than using restraint? 15:54

6 A. Yes.

7 188 Q. And you say that staff didn't have behavioural training
8 which would equip them to use those diversionary
9 strategies; is that right?

10 A. Not all staff would have had, it depends on if they 15:54
11 were -- just not all staff would have had training. If
12 you have got nursing auxiliaries coming in, not all
13 staff would have had behavioural support training. We
14 did start, and certainly when we moved to the Iveagh
15 Centre we did start doing training sessions with staff 15:54
16 on behavioural support plans and de-escalation
17 techniques and things to use, yes.

18 189 Q. Who would have then made the decision, if a patient was
19 acting in a certain way, whether to go for restraint or
20 whether to try to use a diversionary tactic, would that 15:55
21 have been left to the individual staff member present
22 on the ward with that patient or was that decided at a
23 different level?

24 A. Generally restraint was only ever used with us if in a
25 more emergency situation, if there was going to be harm 15:55
26 to the individual themselves or there was going to be
27 harm to another person. You wouldn't have used
28 restraint if there was nobody going to come into any
29 direct harm or anything. You wouldn't have used

1 restraint and certainly the staff would have used
2 redirection things as activities or 'do you want a
3 drink a water' or 'do you want something' or taking
4 them away from the situation. Sometimes it would have
5 been as simple as asking if they wanted to go for a 15:55
6 walk or taking them out of the environment they were
7 in.

8 190 Q. Then can I take it from your evidence in an emergency
9 situation or if there was a patient acting in a certain
10 way it would be left to whatever staff member, whatever 15:56
11 level they may be, as to whether or not restraint was
12 appropriate in that particular circumstance?

13 A. Yes, yeah.

14 191 Q. DR. MAXWELL: Can I just clarify, are you saying that a
15 healthcare assistant could make that decision? 15:56

16 A. Sorry?

17 192 Q. DR. MAXWELL: Are you saying that a healthcare
18 assistant could make that own decision to use restraint
19 or would it have to be a registered nurse?

20 A. If a healthcare assistant was in a situation where they 15:56
21 were being attacked, would have been trained with MAPA
22 so they would have been trained to -- but normally at
23 that stage they would have been carrying alarms so they
24 could have pulled an alarm to get other people there
25 which would have been bringing in senior members of 15:56
26 staff.

27 193 Q. DR. MAXWELL: So if you had a healthcare assistant, and
28 as you said, they hadn't all always had the full
29 training, would they be able, as a self-defence

1 mechanism, use restraint?

2 A. Only if they had MAPA training.

3 194 Q. DR. MAXWELL: Only if they had MAPA training. But
4 healthcare assistants with MAPA training could decide
5 to use restraint without reference to a register nurse 15:57
6 --

7 A. If they were then --

8 195 Q. DR. MAXWELL: I understood why, I am just clarifying --
9 A. They would be able to use it, yes, they would have to.

10 MS. BRIGGS: Christine, that's all the questions I have 15:57
11 for you at this stage. The Panel might have some
12 questions and I am going to hand over to them.
13

14 MS. KEENAN QUESTIONED BY DR. MAXWELL:

15 15:57

16 196 Q. DR. MAXWELL: I just wanted to ask a general question
17 about how prepared staff are. We know most people with
18 learning disabilities will not get into a setting like
19 Muckamore or even the Iveagh Centre. Do you think that
20 the learning disability registered nurse training 15:57
21 really prepares people for these very complex patients
22 or would they need additional training?

23 A. I think that there is certainly, that I know in my
24 experience over this number of years, the level of
25 behaviour, the intensity and the frequency and the 15:57
26 violence has really increased. It has become much more
27 violent and certainly from what I would have started
28 with in behavioural work 20 years ago. I think that
29 we're not really prepared for it. We really don't have

1 -- I don't think there is a great understanding of the
2 level of behaviour and how to cope with it and how to
3 manage that. I don't really know what the answers are.
4 I think certainly people, it needs to be addressed, the
5 sort of high levels of behaviour that people are coping 15:58
6 with and how, what is their expectation of how they
7 respond to that. I'd be fairly concerned that so many
8 people now are walking away and sort of saying we're
9 not going to do this job because it is becoming
10 increasingly difficult, because they are frightened of 15:58
11 litigation and all the sort of things around it, they
12 don't want to work in behaviour work and it' become
13 increasingly difficult. Like I know even for myself in
14 the Iveagh Centre, we would have worked a lot on
15 incentive plans where we would have worked on building 15:59
16 up the reward based system and on these incentive plans
17 and we worked very closely with the children on those
18 plans and with the families. But we were getting very
19 much like RQIA were saying they didn't want incentive
20 plans, that it was a child's right to go out to the 15:59
21 cinema on a Friday night even if they had displayed all
22 of this negative behaviour, which was quite difficult
23 because we always worked under the principles of
24 normalisation. And certainly under the principles of
25 normalisation if your own child at home, if they 15:59
26 misbehave, if they were going to the cinema you would
27 say well I think we'll have to leave that or you are
28 grounded. And it's not that anybody ever wished to be
29 hard. I always felt for our children we wanted the

1 very best for them and we wanted them to have the best
2 life they could lead. You have to have those kind of
3 boundaries set round them. I think that they have all
4 become eroded away now and I don't know how they are
5 going to manage it. 16:00

6 197 Q. DR. MAXWELL: would it be fair of me to say that you
7 feel that perhaps these patients with very complex
8 needs who present quite a challenge to staff?

9 A. Yes.

10 198 Q. DR. MAXWELL: They need more preparation than the first 16:00
11 registration for a learning disability nurse currently
12 provides?

13 A. Yes, I think there certainly needs to be more input put
14 into the complexities of their behaviours, the function
15 of their behaviours and how the staff actually address 16:00
16 those behaviours, there needs to be a lot more
17 training.

18 199 Q. DR. MAXWELL: That might be a post-registration
19 qualification to work in these very intense
20 environments? 16:00

21 A. Yes, I think so.

22

23 MS. KEENAN QUESTIONED BY THE CHAIRPERSON:

24

25 200 Q. CHAIRPERSON: could I just pick up something you just 16:01
26 said which was that the RQIA didn't like
27 incentivisation or stopping a child, for instance,
28 going to the cinema because it was the child's right to
29 go to the cinema, how did the RQIA indicate that they

1 didn't like that?

2 A. Maybe not, they rarely went so much, they weren't very
3 keen on incentive plans. They felt that incentive
4 plans, that a child didn't have to work to do anything
5 to gain rewards, that it was their right to have them, 16:01
6 that they didn't have to earn them. And so it left
7 you, it left you in a position that how do they want us
8 to change behaviour, how do they want us to manage
9 behaviour. We can't just wave a magic wand and change
10 somebody's behaviour. We have to look at all of the 16:01
11 things that we can use to help that person live the
12 best life.

13 201 Q. CHAIRPERSON: I just want to follow this through. How
14 did you find out that the RQIA didn't like incentive
15 plans? 16:02

16 A. They said it.

17 202 Q. CHAIRPERSON: In a report?

18 A. In a report, they didn't like incentive plans.

19 203 Q. CHAIRPERSON: But of course it is up to the management
20 of the hospital what they actually do, what they don't 16:02
21 do, you don't have to follow what the RQIA say, so how
22 would it have been fed down to you?

23 A. How did it filter down to me?

24 204 Q. CHAIRPERSON: Yes?

25 A. Because I was the one writing incentive plans. It was 16:02
26 just -- and coming around that time, that was when I
27 was coming up to retirement and I was leaving then and
28 so --

29 205 Q. CHAIRPERSON: So without naming names, who would say to

1 you the RQIA don't like incentive plans so we are not
2 going to do incentive plans anymore?

3 A. Management.

4 206 Q. CHAIRPERSON: Did that happen?

5 A. Yes, mm-hm. 16:02

6 207 Q. CHAIRPERSON: And did you argue back or how did it
7 work?

8 A. Well I felt that the incentive plans were the only way
9 we could manage and I didn't know what else they could
10 put in place of the incentive plans. Certainly if 16:03
11 anybody could have advised me on how to manage extreme
12 challenging behaviour in any way, I would have done it.
13 I would have used whatever.

14 208 Q. CHAIRPERSON: And when you push back in that way, what
15 reaction did you get from management? 16:03

16 A. Well we continued to use our behaviour support plans
17 right during the time that I was there.

18 209 Q. CHAIRPERSON: And management allowed you to do that?

19 A. Yes.

20 210 Q. DR. MAXWELL: Can we ask who management are? 16:03

21 CHAIRPERSON: Yes.

22 211 Q. DR. MAXWELL: Management is bit of a broad term?

23 A. Yes, management is a broad term.

24 212 Q. DR. MAXWELL: who do you mean by management, do you
25 mean your line manager? 16:03

26 A. Line managers, yes.

27 213 Q. DR. MAXWELL: Or do you mean the clinical director?

28 A. No, not the clinical director, it came from my line
29 manager.

1 214 Q. DR. MAXWELL: Your line manager who is in Psychology?
2 A. Not from Psychology, from the nursing end.
3 215 Q. DR. MAXWELL: Your nursing line manager?
4 A. Psychology would have been okay.
5 216 Q. DR. MAXWELL: I would be surprised at Psychology saying 16:04
6 it.
7 A. Psychology was quite okay with them.
8 217 Q. DR. MAXWELL: It was your line manager within the
9 nursing management?
10 A. In the nursing end, yes. 16:04
11 DR. MAXWELL: Thank you.
12 CHAIRPERSON: Can I just thank you very much for coming
13 to assist the Inquiry. You are, as you probably know,
14 our first witness in this module dealing with members
15 of staff and getting the insight into life at Muckamore 16:04
16 from a staff perspective is obviously of great
17 importance to the Inquiry and it certainly seems, to me
18 at least, you have been very frank and very balanced
19 and it has been very useful to hear from you, so can I
20 thank you very much indeed. 16:04
21 A. Okay, thank you very much.
22 CHAIRPERSON: Is it 10 o'clock tomorrow?
23 MS. BRIGGS: 10 o'clock tomorrow, Mr. McEvoy is taking
24 the witness.
25 CHAIRPERSON: Excellent. Okay, thank you very 16:05
26 everybody. 10 o'clock.
27
28 THE HEARING ADJOURNED
29