MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 8TH MAY 2024 - DAY 80

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

GWEN MALONE STENOGRAPHY SERVICES

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WITNESS PAGE

THE INQUIRY RESUMED ON WEDNESDAY, 8TH MAY 2024
AS FOLLOWS:

CHAIRPERSON'S STATEMENT:

09:47

CHAIRPERSON: Thank you, thank you very much. Well, welcome back everybody, and thank you for your patience.

Before we hear from our next witness, I want to say a few words about the programme for the Inquiry as we move to the final stages of evidence. 10:06

Obviously, we've had to change the timing of evidence as a result of the break that we've just had and I hope it will be helpful if I can set out what the Inquiry is intending to do. 10:06

So, first, in relation to this week and next, I ought to say this: one of the witnesses we expected to be able to call today has a personal family-related health issue justifying why she couldn't be called this week. Accordingly, I've asked her to attend next week, when we hope she'll be able to come. 10:06

10:06

The effect is that we have one witness to be called today, as you know, and two statements to be read - H471 and H137. Another witness, H231, was expected to be able to give evidence orally tomorrow, but I've

received medical evidence which makes it clear that it would be inappropriate to call her to give evidence at any stage, at least in the near future, and she'll, therefore, be read. So, thus, there are two significant witnesses this week that have effectively been lost.

I want to make it clear that I do not release witnesses from giving evidence on medical grounds without careful consideration and I will always ask to see appropriate medical evidence. Each case has to be dealt with on its own merits.

So, instead of having a reading day tomorrow, Thursday, which would, in any event, have been less than half a day, I've decided that we will not sit at all tomorrow and the statements to be read will be fitted into the evidence on a fuller sitting day next week. There's no point in everyone gathering for an hour or so of evidence if we can avoid it, which we can, but it does mean that this week is very much shorter than the Panel would have liked.

On Monday of next week, 13th of May, we'll hear orally from A12, and H231 will be read. On Tuesday, H284 and H73 will both be called to give oral evidence. On Wednesday of next week, H260 will give oral evidence and the statements of Geraldine O'Hagan and H339 and H230 will be read.

I'd like to say a few words about the statement of Geraldine O'Hagan, a family liaison officer, who many in this room will have met and some may have worked with. Her statement has only recently been finalised and the Inquiry has processed it as quickly as possible for disclosure to CPs, but there are redaction issues arising in respect of the exhibits that will have to be resolved at a later stage. 10:08

Now, in normal circumstances, we wouldn't serve a statement without its exhibits, nor would we read a statement earlier than the protocol on the service of statements would normally allow. But as anyone who reads her statement will quickly understand - I don't think it's been served yet, but it's going to be served very shortly - as anyone who reads her statement will understand, there are very exceptional reasons to do so in her case. She's very keen to be able to hear her statement being read and we're making arrangements for her to be able to view the proceedings and to hear her statement being read, which will take place next Wednesday, as I've said. 10:09 10:09

Dealing with the rest of the programme up until the end of live evidence before the Inquiry: 10:10

We won't be sitting on Monday 20th May or Tuesday 21st May. This short break is intended to give

everyone the opportunity of reading the Ennis bundle of exhibits and statements, as well as ensuring the service of the majority of the evidence in relation to organisational Modules 1 to 5. So the plan is that we'll sit on Wednesday 22nd of May through to 30th of May, with the usual Friday breaks, and we hope to deal with Modules 1 to 5, so that is: Module 1, patient advocacy and representation; Module 2, professional education; Module 3, professional regulation; Module 4, the police role in safeguarding and responding to allegations; and Module 5, RQIA and the Mental Health Commission. 10:10 10:10

We then propose to revert to staff evidence from 3rd June to 11th of June, and I'm going to say a little bit more about the process of taking statements from staff in a few moments. 10:11

From 17th of June, we will turn to the Ennis module, which is evidence Module 6, and that will take us to 20th of June, and on 24th June we intend to hear organisational Module 6, dealing with resettlement, which will take us to the summer break. So that's the plan up until the summer. 10:11 10:11

We'll start again on 9th of September and sit until early November, during which time we'll hear the remaining evidence, to include any remaining Module 1 to 6 evidence, as well as Module 7, which is MAH

operational management; Module 8, professional organisation and oversight; Module 9, the Trust Board; and, finally, Module 10, the Department of Health.

Now, during the recent pause, Cleaver Fulton Rankin Solicitors have been working on the Inquiry's behalf taking statements from members of staff. That process has been slower than we would have liked, but the Inquiry is grateful to the great majority of the members of staff who have been asked and have been willing to give their statements voluntarily. 10:12 10:12

I would like to explain why I have insisted on a process whereby Cleaver Fulton Rankin, or CFR, take the statements from members of staff. What seems a long time ago now, I met with patient relatives and explained why it was necessary for them to make statements through independent solicitors rather than to their own solicitors, which is what the majority of them wanted to do. One of the reasons I then gave was that, unless I insisted on that then, it would be far harder to insist on that happening with members of staff. I made a public statement about that on 23rd of November 2022 and there was some scepticism then that I would require the same process of the Trust staff when time came for them to make their statements. The other main reason given was that, under the Memorandum of Understanding with PSNI and PPS, it was important for the Inquiry to retain a degree of control over the 10:12 10:12 10:13

statement-taking process. That was so that I could ensure, as far as possible, that we kept the assurances the Inquiry had given not to do anything to undermine the criminal process. It is principally for those reasons that I've required all members of staff to make statements through CFR Solicitors rather than to their own solicitors. I am sorry if that process has caused some frustration to some witnesses or to their solicitors, but it is, in my view, the right thing to require. 10:13 10:14

In relation to evidence Module 6, the Ennis Report, I have again asked witnesses to make their statements through Cleaver Fulton Rankin. Prior to statements being taken in relation to the Ennis Report, a bundle was carefully compiled by counsel to the Inquiry which comprised those documents which the Inquiry felt were most relevant to the issues the Inquiry had to deal with in relation to that report. There was nothing to prevent witnesses referring to other documentation as they thought necessary, but the Inquiry's approach was an attempt to avoid duplication of material which other witnesses had already produced. Fortunately, all witnesses bar one have complied with the Inquiry's request to make statements through Cleaver Fulton Rankin in relation to Module 6 and the Ennis Report. One witness, giving evidence on behalf of the Belfast Trust, has, unfortunately, refused to do so. Quite apart from the fact that was in contravention of my 10:14 10:14 10:14

direction, one result has been an unnecessary duplication of materials, which the Inquiry sought to avoid. When we serve that statement, we will explain more fully what has occurred and the consequences.

10:15

Dealing with other issues:

The observant among you may have noticed that there have been some variations to my Restriction Orders.

10:15

Restriction Order No. 4, the General Staff Restriction Order, has been amended to allow for the position where solicitors acting on behalf of the Inquiry are required to put to a witness an allegation made by another member of staff. That has the effect that the true name of a member of staff, who is otherwise ciphered, needs to be known for the witness to be able to respond appropriately to the allegation; thus, the amendment was necessary.

10:15

10:15

There's also been an amendment to the Order relating to the Ennis Report and the evidence in Module 6, which is to come.

There was originally a limited Restriction Order No. 15, which has now been revoked and replaced by Restriction Order No. 53, which deals holistically with all of the redactions to be made to the Ennis bundle and the statements.

10:16

I hope that's been helpful in relation to keeping people informed both as to progress and to process.

So, Ms. Bergin, are we ready for the next witness? 10:16

MS. BERGIN: Yes, thank you, Chair, we are. Chair and Panel, the witness is Dr. Clare Byrne. There is a Restriction Order in respect of this witness, and I would ask for the application to be restricted in the usual way, so if the feed could please be cut. 10:16

CHAIRPERSON: Yes, certainly. So, if we could cut the feed to Room B and I will make a Temporary Restriction Order in relation to the application so that, should I make the Restriction Order, it will be effective. 10:16

(RESTRICTED SESSION)

OPEN SESSION RESUMED

CHAIRPERSON: Well, just indicate to Room B that a Restriction Order has been made in relation to some very short passages in the statement of this witness which are not going to be adduced into evidence. 10:19

MS. BERGIN: Yes, thank you. The statement reference for Dr. Clare Byrne is STM-220, and I do not intend to read out the full statement but intend to just briefly summarise it. 10:20

CHAIRPERSON: Yes, I mean, I absolutely agree to summarising, and I think that's the way forward, just

bearing in mind that this is a Public Inquiry and the public are entitled to know, in general terms, what's being said.

MS. BERGIN: Certainly. Thank you, Chair.

10:20

DR. CLARE BYRNE, HAVING BEEN SWORN, WAS EXAMINED BY MS. BERGIN AS FOLLOWS:

CHAIRPERSON: Good morning. Can I just welcome you to the Inquiry. 10:21

THE WITNESS: Good morning. Thank you.

CHAIRPERSON: I am sorry, I don't think we have met before, and I'm sorry you've had to wait in that little room while I delivered quite a long address to the members of the public, but thank you for coming along 10:21 to assist us, thank you for your statement, and I'm going to hand you over to Ms. Bergin, who is going to...

MS. BERGIN: Thank you, Chair.

1 Q. Good morning, Dr. Byrne. We met briefly this morning 10:21 and I explained how we will be dealing with your evidence. As you know, I will be summarising your statement, but, as I've explained, the Panel and the Core Participants all have seen a copy of it.

In terms of how we proceed with your evidence, although 10:21 we will not be going through your statement, you will see that you should have in front of you both a copy of your statement and also a cipher list.

A. Yes.

2 Q. So, when you're referring to any members of staff, if I could ask you to check the cipher list and, if in doubt, just write their names down and hand them to the secretary, okay?

10:22

The other thing as well is that we have the stenographer here as well, so I certainly have to remind myself also to just try and speak slowly and clearly into the microphone so that she can take a note, okay?

10:22

So, the first thing I am going to ask you to do is turn to your statement, okay? And your statement is dated 28th March 2024?

A. Yes.

10:22

3 Q. And you've signed a declaration on the final page. So, could I just ask you, are you content to adopt that statement as your evidence before the Inquiry?

A. I am.

4 Q. Great, thank you. So I am going to now begin, as I said, by summarising your statement, and then we'll have the opportunity to go through further information in my questions and the Panel may also have some questions for you.

10:22

10:22

So, Dr. Byrne, you are a chartered forensic psychologist and, within your statement, you outline the various professional bodies and associations that you're a member of, and you've also helpfully provided

us with a copy of your CV, which I am not going to go through in detail. Since 2017, you have been a Specialist Forensic Psychologist Band 8A for the Belfast Trust Community Forensic Intellectual Disability Service? 10:23

A. Yes.

5 Q. Where you provide specialist forensic, psychological assessment, treatment and consultancy to adult Learning Disability Service teams?

A. Yes. 10:23

6 Q. And as part of that role, you worked at Muckamore between September 2017 until November 2018?

A. Yes.

7 Q. Is that correct?

A. That's right. 10:23

8 Q. And when you started working in Muckamore in 2017, you were based within the Psychological Services team in the administrative offices, and you then, after a period of time, transitioned to also working in the community? 10:23

A. That's right, yeah.

9 Q. And in terms of, then, your work at Muckamore, you worked at Sixmile Ward?

A. Mhm-mhm.

10 Q. And you carried out pretest assessments and 10:24 consultations with patients before they began therapy; you worked with more able patients who were able to engage in therapy, and we'll come to that; you delivered therapeutic group work called Motivational

Enhancement Group, and I'm going to refer to it as 'MEG', if that's all right?

A. Yes, yes.

11 Q. And you delivered that along with two or three other members of staff -- 10:24

A. Yes.

12 Q. -- for a period of six weeks between February and March 2018, and that was focused on developing patients' ability to cope with their feelings and people skills, and after that -- the MEG was sort of a precursor, so, 10:24 after that, you then were involved with other staff in delivering weekly group Dialectical Behavioural Therapy - DBT - with six to eight patients between April and November 2018 at Moyola?

A. Yes. 10:25

13 Q. And your work included individual group -- individual and group therapy sessions and particular work with two patients in a group in Moyola therapy room. And you've explained in the course of your statement that DBT is a treatment which is recommended for those affected by 10:25 borderline personality disorder, but it has also shown to be effective for those affected by emotional, psychological or behavioural dysregulation?

A. Yes.

14 Q. And you've said that there was a DBT therapy manual at 10:25 Muckamore and that the group work that you were involved in delivering was also facilitated by a group of people or a team of people --

A. Yes.

15 Q. -- including nurses, forensic psychologists and behaviour support staff. You were not involved in multidisciplinary team meetings in relation to the patients that you worked with, but those who were involved in the DBT therapy attended what you've called "DBT consults" -- 10:26

A. Yes.

16 Q. -- to discuss the progress of patients. And in terms of the number of therapy sessions, that would depend on a patient's particular needs and, at the end of treatment, you would write up a formal report on the skills the patient had developed throughout the therapy, which was separate from their ward treatment plan. And finally then, you've indicated that you and your team developed the DBT therapy and updated it, based on patient feedback and experiences of delivering it? 10:26

A. So, yes, it is an adapted version of DBT that's delivered, obviously adapted for people with intellectual disabilities, so that an adapted version had been developed by a team before I came into post and they, kind of, were continuing to review and update it while I was there. 10:27

17 Q. Great, thank you. So, that's a very broad summary, but hopefully accurately summarises your involvement in providing therapy at Muckamore. So, if I can begin by asking you hopefully, it's a rather broad but hopefully a straightforward question, which is, could you describe in your own words what the role of a forensic 10:27

psychologist is?

A. So, in terms of my own work as a forensic psychologist, I would work with people to try and understand the people who have committed offences, got into trouble with police or done something to harm other people, and I would work with them to understand how those things happened, where those behaviours came from, understand the nature of the risks of anything like that happening again in the future, and work with the person to be able to manage and minimise those risks. 10:27 10:28

18 Q. And at paragraph 4 - I'm going to be referring to paragraphs as we go and I don't necessarily need you to turn to every paragraph, but it's just for the assistance of yourself and the Panel - at paragraph 4, you referred to your forensic psychology degree and then also your doctorate, and my question about that is, did you have any specific placements or training throughout those education experiences in learning disability? 10:28

A. So my background was that my training, when I was qualified as a forensic psychologist, was working in the Prison Service, so I would have worked with a broad range of people there, not specific to learning disability. So when I came into the post that I'm in now in the intellectual disability service, then I would have had extra support and I guess adapting the knowledge and training that I already had to the work. 10:28 10:29

19 Q. But just going back, sorry, to your actual, I suppose, educational experiences in terms of your degree and

your doctorate, did that include any learning disability specific training or placements?

A. No, it wouldn't have.

20 Q. Okay. And then as you've already gone on to say then, when you started at Muckamore then, you were involved in learning disability work? 10:29

A. Yes.

21 Q. Sorry, please go ahead.

A. I guess clients that I'd have worked with in my previous post over a number of years would have had a range of levels of ability. Some of those would have included people with intellectual disabilities and also people with kind of -- you know, between intellectual disability and the more able, so a broad spectrum, so I'd already have had experience of working with people with intellectual disabilities and also other difficulties and adapting work to suit the individual needs. 10:29

22 Q. And so I suppose the post that I've described earlier that you took up in 2017 was specifically focused on intellectual disability -- 10:30

A. Yes.

23 Q. -- in terms of the intellectual disability service, and you've said that you did have some previous experience, in the round, in your previous post, but -- 10:30

A. Yeah.

24 Q. -- but did you have actual specific experience in a learning disability post at all?

A. No.

25 Q. No. And in terms then of, I suppose, how you felt equipped in that job, you've indicated that your initial induction at Muckamore included various sort of training, but it didn't include learning disability training. Was there any sort of formalised or maybe more informal learning disability training that you received while you were at Muckamore? 10:30

A. So that would have really been through, I guess, informal mentoring and support, so working under supervision, having advice and support from my supervisor and the team and I guess discussing and checking out, you know, the nature of adaptations and maybe discussing work with individual clients and getting advice and support around tailoring the work to those individuals' needs. 10:31

26 Q. And the DBT, you've already indicated that that was an adapted form of DBT?

A. Mm-hmm, yes.

27 Q. And I think in your statement you actually say that it was developed in Northern Ireland and training was provided to the staff at Muckamore before -- 10:31

A. Yes.

28 Q. -- you came on site. So, the first question there is, did you have any previous experience of DBT therapy?

A. So, I had completed training to be a DBT therapist, so I hadn't delivered DBT prior to coming into this post, but what I had, I attended training to deliver the DBT skills group, which is a group kind of component of the therapy, and then I'd also completed what's called DBT 10:31

foundational training, so it's a longer training that you go through to -- in order to be a -- do the individual DBT therapy, one-to-one with people, which is the other kind of -- one of the other main elements of DBT therapy, so I would have been through that training as part of the preparation for moving into the post.

29 Q. So that was already when you were with the Trust, was it, before you moved into the Muckamore role?

A. Yes, so I completed the training just before joining Muckamore. 10:32

30 Q. Okay. And did that include any element of learning, specifically DBT focused on learning disability patients?

A. So, no, that training was general training in DBT, delivered by the DBT trainers. So the adaptation is -- the kind of training around that was around, and again, I suppose delivered more informally in-house with the team that I joined, was around sharing and showing me and teaching me about the adapted version and how it's delivered and the way the adaptation is made and the -- 10:32 10:33

CHAIRPERSON: Before we look at the adapted version, I am probably the only one on the Panel who doesn't know much about DBT. Can you just give me a thumbnail --

A. Yes. 10:33

CHAIRPERSON: -- sketch of what that actually means for the patient and what you do.

A. Yes. So, DBT is a therapeutic approach. It's developed -- was developed for people who have

difficulty regulating --

CHAIRPERSON: Keep your voice up, sorry. Keep your voice up, if you could.

A. For people who have difficulty regulating their feelings and their behaviours and so it includes one-to-one therapy sessions, so they are normally held weekly, where the person -- we would identify kind of targets for therapy, so what are the behaviours or difficulties that the person is facing that are causing problems for them and for other people in their lives that we want to be able to reduce or to change and what are their goals for therapy, and the individual sessions would be about exploring people's -- the person's behaviour, you know, "How have you been getting on this week?" What behaviours have been coming up that we're trying to address, and, kind of, understanding, you know, so "what was the situation that led to that behaviour coming up?" And exploring what happened. "How could you deal with that more skillfully in the future?" And kind of coaching --

CHAIRPERSON: So it's a form of talking, it's a talking therapy?

A. It's a form of talking therapy, yes, but it is quite behaviourally-focused as well in terms of trying to understand where behaviours are coming from and how they are maintained and finding ways then to intervene and change those, and individual sessions focus on that. And then alongside that, at the same time then, there is a skills group, which is run for kind of a

finite period of time, and people go through it together and it's focused on teaching everybody in the group a set of core skills that we know are helpful, so it teaches mindfulness, it teaches people skills, social skills, it teaches emotion-regulation skills and it teaches skills for coping in crisis, so when you're too dysregulated to be able to really, you know, sit down and think things through or work on your people skills, "what can I do in this moment to help me get through this moment without making things worse or causing harm to myself or somebody else?" 10:35 10:35

CHAIRPERSON: It sounds as if it requires quite a high degree of engagement for it to work with the -- from the patient?

A. Yeah, so it is quite an intensive process, yes. 10:36

CHAIRPERSON: Okay, sorry.

MS. BERGIN: No, not at all. Thank you, Chair.

31 Q. And then you've described what DBT is. I suppose could you -- and you have referred to the modified or adapted version of DBT. 10:36

A. Mm-hmm.

32 Q. Could you give the Panel some idea, if you can, of some of the differences in terms of delivery of DBT to, I suppose, non-learning disability clients or patients and learning-disability patients, if you can? 10:36

A. Yes. So I suppose the simplest thing would be for me to talk through some of the adaptations that are made. So, for example, in running the skills group, obviously the language has changed quite a lot. Some of the

concepts are -- the concepts that are taught and talked about, are kind of reduced and simplified. There's one or two of the concepts that have kind of been taken out because experience had suggested that they were kind of not helpful to try and teach because it was kind of 10:37
overloading people, so kind of reducing down and simplifying the number of concepts that are talked about and taught, obviously changing the language to make it really accessible, and then also the main adaptations around how they are taught, so rather than 10:37
kind of sitting and discussing or talking through examples in a more abstract way, which might happen in a mainstream DBT group, running kind of -- using physical practical examples to illustrate points, so we would use props and activities and getting up and 10:37
moving about and doing things with objects and pictures and symbols, you know, to convey the same learning but taught in a different way to make it accessible, so it's less verbal and less abstract and more concrete, but ultimately, I guess, the purpose is still about 10:38
helping people to understand. So, say, for example, if we're talking about people skills, you know, and social skills, you know, sometimes we have problems with other people and some of those problems will be helped if we learn how to communicate with other people really 10:38
clearly and calmly and openly, be honest, be direct, be kind, those types of things, so, you know, it's getting that message across but in a way that's readily kind of taken on board and can be practised by the person who

maybe has the intellectual disability, so you're not asking them to do something that's unrealistic for them.

33 Q. Okay, thank you. In terms, then, of the delivery of these two types of therapy, can you help us understand a bit more your role in terms of how you came to be, I suppose, placed in Muckamore to deliver it. So you've indicated that the Muckamore staff were already adapting and using, I suppose, forms of DBT before you arrived there, so is this something that had been delivered before you came and then after you left? If you can just sort of put that into context for us, please. 10:38 10:39

A. Yes, the DBT was already running in Muckamore and had been -- I don't know exactly for how long, but for a number of years. So what they had done was to develop this adapted version of DBT and implement it and try to train staff as broadly as they could so that it could be used across as many patients as possible and that staff have a kind of common language that they can share to talk about, you know, the skills, to try and encourage people to use those skills. So it was already running and had been delivered, and I kind of just -- when I joined the team, I came in and just formed part of that and helped to deliver. When somebody is going through DBT, they'll do their own one-to-one therapy and work through it, they will attend the skills group, so learning, going through each of those modules with a group of people, and then 10:39 10:39 10:39

often, depending on the person's needs, the one-to-one work will carry on afterwards and sometimes people might go through more than -- might go through the skills group more than once, so, again, over time, are continuing working on their skills and potentially go back through another cycle of the skills group and learn afresh and continue to try applying their learning in their day-to-day life. So that's kind of what was -- that was already going on and happening in the background and, as I joined the team, I was supporting that and became part of that. 10:40 10:40

34 Q. So, in terms of, I suppose, your, then, period of involvement at Muckamore; in your statement, you refer to being based, I suppose, permanently in the admin building and then transitioning to also working in the community, so were you working in both Muckamore and the community at the same time? 10:41

A. Yes. So --

35 Q. I am sorry to interrupt you. Just before you answer, if you could also address for us, I suppose, what the division of your time would have been on a weekly basis between your responsibilities at Muckamore and in the community, please. 10:41

A. Yes. So, I guess it progressed over time. The post that I'm in is primarily a community post, so the Belfast Trust works, obviously, to Muckamore as well as the community, so we have kind of links in the community and in the hospital. So, when I first took up my post, my line manager was on maternity leave, so 10:41

I was -- I went to work -- so, when I first started, I was based at Muckamore full-time while I was -- so that I could be supervised by her line manager while I was becoming familiarised and getting my training and becoming -- you know, taking up the role, if you like, and, you know, learning the things that I needed to learn. So, partly for practical reasons that was -- I went to Muckamore for the first few months of my post. So, long term, it became -- you know, over time, I spent more and more time in the community, and after I had been in post, I'm not sure how long, maybe a year, there was myself and another forensic psychologist in the team together and I was kind of moved out to be full-time in the community and she then remained in the hospital with -- you know, split between the hospital and the community. So, I'm sorry, that wasn't a very straight answer to that, but it evolved over time. 10:42 10:42 10:42

36 Q. Okay. And I suppose in terms then of, during that period of time when you were still then working at Muckamore, I suppose so that we can understand what exactly your role was in terms of providing psychology services -- 10:43

A. Yes.

37 Q. -- was your role, and I suppose if I say limited, but I don't mean that in a negative way, but was the role limited to providing the specific types of EMG and DBT group and one-to-one sessions, or did you also have input with the broader psychology team, providing other types of therapy to patients? 10:43

A. It was mainly focused on providing the DBT therapy. Yeah, yeah, so -- yeah.

38 Q. That's great, thank you. Then, in terms of the patients that you were actually dealing with, I think you say in your statement that it was higher-ability patients. So I take from that that, then, there's, I suppose, a level of learning disability perhaps where DBT isn't as effective or isn't possible? 10:43

A. Yes.

39 Q. Are you able to say any more about that, please? 10:44

A. Yes. So, obviously, as we were saying earlier, it is a talking therapy, ultimately, and it requires you to be able to sit and discuss and reflect on, you know, what's been going on in your life this week or today, you know. So, for example, maybe if there had been a particular difficult situation facing the person that week and something had happened, you'd be -- we would be kind of talking through what happened, "How did you feel?" What -- you know, "Can you remember anything about it? Who said what? What did you say? What did that person say?" So, obviously there's a reasonable amount of cognitive ability required to be doing that, so people with more severe intellectual disabilities may not be able to reflect on their experiences in the same way and may not even be able to communicate verbally in a way that they could have those conversations, and so, obviously, in that case, something like DBT is, you know, less helpful and, I guess, depending on the severity of the disability, not 10:44 10:44

relevant at all.

40 Q. And were you involved then in providing any other types of psychology input to patients for whom DBT wasn't suitable in Muckamore or --

A. No, no. 10:45

CHAIRPERSON: And who made the choice? How did you decide which patients you were going to see and who your sort of assistance wouldn't help?

A. So, that would have been the broader hospital team, so I guess the people within the wards, working with the 10:45 patients, would have an understanding of what DBT is, what it does and who it can be helpful for and would kind of identify people that they thought might be able to benefit from DBT, and then the team would then take that and kind of recommendation and then maybe work 10:46 with the person to talk to them about whether that was something that they would do.

CHAIRPERSON: So would that assessment be made by a psychologist or by nursing staff or by a doctor?

A. In terms of identifying people, potentially? 10:46

CHAIRPERSON: Yes, who were going to come through your door.

A. I think that would be, like, a multidisciplinary process. So, I mean, in terms of treatment planning, you know, DBT would be one of the options that would be 10:46 considered, as far as I am aware.

CHAIRPERSON: And then would you conduct an assessment when they first walked through your door, as it were?

A. Potentially, yes. So, again, it kind of depends on the

person. Some of the patients were already very well known to other staff and maybe some had already kind of agreed to engage and to do that work, and so, at that point, my role would really just be to take that forwards with them, but, yes, at other times it might be about going to somebody and talking to them about DBT, what's it like, you know, if you're going to do it, what would that look like for them and checking out whether they were willing and gave their consent to do that, and then, you know, planning, you know, what they wanted to look at, what we might work on together, that type of thing. 10:47 10:47

41 Q. MS. BERGIN: Thank you. And in your statement, around paragraph 9, you refer to, I suppose, treating patients in Sixmile Ward, but then, it seems, being based at Moyola, so were you dealing with patients from both the Sixmile Ward and Moyola Ward? 10:47

A. So, Moyola was a -- kind of where the day activities -- it was, like, a building where lots of the day activities were held. There was a therapy room there, which is where the DBT skills group was delivered, and patients would come to it from different wards. So the patients I worked with primarily were Sixmile patients because those are the ones that the forensic team are supporting specifically. But patients would have come from elsewhere in the hospital also to do the skills group. 10:47 10:48

42 Q. And you'd referred earlier to the multidisciplinary team meetings, so you weren't involved in those --

A. No.

43 Q. -- directly? Why -- I suppose can you help us understand why you weren't involved in those?

A. I suppose because my role was very focused on the DBT delivery; you know, I wasn't part of the wider hospital team. I was kind of filling this specific role in the time that I was there and so I wasn't involved in -- so I wasn't going to ward rounds or involved in treatment planning or, you know, the kind of day-to-day running of the hospital, if you like, so it was quite a focused, specific role that I had, that sat separate. 10:48 10:49

44 Q. You've referred in your statement to the weekly DBT consult meetings which were attended by a range of professional staff - psychologists, nurses, behavioural assistants - and that there were, I suppose, more informal opportunities to share; you've discussed in your statement having conversations with senior nurses about the progress of patients, therapy and feedback during those sessions. Was there any sort of formal way for the DBT consult, I suppose, outcomes to be shared with multidisciplinary team meetings, or how was the progress that was made in therapy fed into the patients' overall behavioural support plans or their multidisciplinary team meetings generally? 10:49 10:49

A. So, obviously at the end of treatment, there is a report written about how the person had got on -- at the end of the group, a report was written about their progress and understanding at the end of it. While the work was ongoing, there would have been kind of

communication all the time, so obviously the staff involved, a lot of the staff involved with delivering DBT were also staff involved in either working on the wards or working in the behaviour teams, and so there would be kind of, I guess, informal communication. So, for example, back to the ward about how somebody had got on in a session, as there was the other way. So, maybe before a session started, you might hear how somebody had been getting on. If there was a particular issue, you would be told and understand what that was, if it might affect how they were in the group that day. Similarly, when I was going to the Sixmile unit to do my one-to-one sessions, so I would have gone once a week to see each person and I would have had a conversation typically with their key worker or with, you know, a member of staff based in the ward, about how the person is doing, is there anything coming up, so I would be kept up to date with what was happening with them, and after my session I would let a key worker know, you know, how we got on. If there was maybe a particular skill that that person was trying to work on, that I was maybe trying to encourage, I would share that information so that, then, that could be supported on the ward as well. So, there was kind of an ongoing flow of information, but probably more informal, from my recollection of it. 10:50 10:50 10:51 10:51 10:51

45 Q. So, just staying on that, then. If we look at both the positive behavioural support planning, which you weren't directly involved in, and then the

multidisciplinary team meetings. So, just so that I understand this correctly, are you saying that your formal report at the end of the therapy block would have fed into either or both of those?

A. So that would have been shared with the team that were working with the patient, yeah. 10:52

46 Q. Okay. And do you think that it would have been of assistance or there would have been any benefit if your, I suppose the updates you've described throughout the more informal updates, had been able to be shared in a more formal way through directly to the PBS or the MDT? 10:52

A. So, I'm not aware of -- I don't recall any real feeling that there was a gap, that information wasn't getting to people, I think, because, you know, it's a reasonably small team of people and that information is flowing, yeah. I can't recall ever having a concern that information wasn't kind of being used, I think is probably the best I can say on that. 10:52

47 Q. Yes. No, that's fine, thank you. In terms then of tracking a patient's progress throughout the course of or at the end of their therapy sessions, did you ever check, for example, whether a patient's behaviour had altered; for example, were they involved in less incidents? Were there less issues about seclusion, or restraint or PRN? Is that something that you had a feel for or were able to actually check? 10:53 10:53

A. So, I -- so, information was gathered before and after the treatment. Now, I wasn't involved myself in doing

that, so I wouldn't have formally, I don't remember formally making those comparisons.

48 Q. But you think other members of your team, is that --

A. Well, so, information was gathered through for -- sort of in terms of evaluation of the programme's effectiveness. 10:54

49 Q. Okay. And --

PROFESSOR MURPHY: Sorry, can I just clarify that.

A. Yeah.

PROFESSOR MURPHY: Was it basically the nursing staff then who were looking at, for example, incidents and whether they were going up or going down, etc.? 10:54

A. I'm sorry, I'm struggling to remember the details of it. I think -- so, the DBT team themselves would have kind of looked at kind of changes post-treatment. Again, I suppose my recollection is, in terms of on-the-ward behaviour and monitoring of the behaviour, again that was kind of more informal and discussions about somebody's progress and how they were presenting. 10:54

PROFESSOR MURPHY: Okay, thank you. 10:55

50 Q. MS. BERGIN: And just to pick up on that. Just in your evidence there, you referred to the DBT team, you know, as if you're not within that team. But I also did want to ask you about, at paragraphs 20 and 32, you make reference to the PBS, the positive behavioural support plans being designed by the Psychological Services team, but you, I think, were in the Psychological Services, so I just think -- 10:55

A. Sorry.

51 Q. -- it would be helpful to understand, I suppose, the differentiation between you and what you're describing as the main team.

A. Yeah, yeah, okay. So -- I will try, and I guess, I suppose, I'm kind of thinking back. You know, you have the Psychological Services team, which would have been quite a broad team, it would have included forensic psychologists, clinical psychologists, behaviour therapists, behaviour nurse practitioners, that, you know, would have been working across the whole hospital and, within that, I suppose, then, there was a smaller group of people who were the ones that were directly involved in delivering DBT, whether that was the skills group or the therapy or, for some of us, both. So I think, does that clarify that? 10:55 10:56 10:56

52 Q. Yes. And then, I suppose -- so then, I suppose, just so that we're clear about what you're saying, you, I suppose, I think you've described, had a very specific role --

A. Yes. 10:56

53 Q. -- which was limited to providing those two types of therapy in that space of time that you were at Muckamore; would that be a correct summary?

A. Yes, yes, that would, yes.

54 Q. In terms of -- you have described, I suppose, the informal information-sharing with nurses and members of staff, to be able to work on any issues or alert them to any issues that the patient was working through or skills that they should be aware of in terms of 10:56

encouraging the development of those skills. You've indicated in your statement that you didn't have any direct contact with families, but do you know if anybody in the wider team that you were working with did, in terms of trying to make families aware that their relative was engaged in this therapy and there were certain skills they were working on so that they could assist with reinforcing those?

A. Again, I think it depended on the person and what their kind of family setting was like, so it would have been different for different patients. I think certainly that would have happened with some of them. I think, with others, maybe the families would have been a little bit less involved, so, yeah. Because I wasn't directly involved in it, it is hard for me to say exactly what that looked like, but certainly -- so, for example, you know, if somebody was maybe going back home or back into the community, that put part of the package of information that you would want to be going with that person would be the skills that they've learned, things that they've found helpful, you know, or that they can be reminded about, that type of thing.

55 Q. Great, thank you. At paragraph 37, you describe Muckamore as "a medically-oriented institution". I wonder can you explain what you mean by that?

A. Yeah. So, I think that was in response to a specific question that I was asked when I was giving my statement. I suppose, I think probably just reflects more broadly the service in Northern Ireland as it is,

which, you know, where there is a kind of fairly medical -- a medical model of understanding mental health, mental illness, so focusing on thinking about, when things go wrong, you know, it's an illness and something's imbalanced, and understanding it from that point of view, and obviously, then, medication being an important part of treatment.

56 Q. At paragraph 38 --

CHAIRPERSON: Well, sorry, before we move on from that, how did that differ from your other experience? 10:59

A. Well, I suppose my other experience would have been -- wouldn't have been from a mental health setting, so I would have been working in a criminal justice setting prior to that.

CHAIRPERSON: Wouldn't you have described that as a medical setting? 10:59

A. Well, so I suppose the -- yeah, the nature of the work and the role that I had was slightly different there. I suppose an alternative perspective is, you know, thinking about understanding people's mental health and mental illness from a point of view of, you know, the experiences that they have had and how those have led them to feel the way they are feeling or to be acting the way that they are acting. 10:59

PROFESSOR MURPHY: But presumably, and don't let me put words into your mouth, but in your community work, didn't you find it was a rather different perspective in terms of their kind of medicalisation of people's difficulties? 11:00

A. Do you mean where I'm based in the community now?
PROFESSOR MURPHY: Yes. And from what I understood of what you were saying earlier, part of your time was spent in the community, even when you were working at MAH. So, what we're asking really is, was there a kind of difference in the culture between the two? Was it very medical in MAH and non-medical in community or did you feel it was pretty much the same everywhere? 11:00
A. I think it is different, you know, and I imagine that reflects the difference in the environment and maybe the needs of the people that are in it as well. Obviously, people in hospital are needing much more intensive kind of support and supervision and input. In the community, it does, like I say, tends to be kind of medically-led and come from a medical model. I guess the work that I do in the community is, yes, would be, I guess, less so, and thinking more broadly about the person's life setting and needs and the kind of social and psychological factors as well as, you know, we also do seek, you know, support and medication, where it's appropriate and needed, and input from the medical side of the disciplinary team as well, but maybe it would be part of a more mixed picture, but again, I suppose it's hard to compare because it's very different, it's people in different situations, working on different things. 11:01 11:01 11:02
PROFESSOR MURPHY: Thank you.
57 Q. MS. BERGIN: We are nearly finished. You refer at paragraph 38 to staffing issues and staffing changes

which you felt meant that, sometimes, the right people weren't on the right ward and you've also referred to learning through conversations with staff that there seemed to be a disconnect between management and day-to-day running of Muckamore. Can you elaborate on what you mean by those, please?

A. Again, I think probably that latter statement was a response to a very specific question I was asked, and I was trying to think back and remember, you know, what my impression had been and what my experience had been while I was based at Muckamore. You know, it's no secret that, in Muckamore, as in many other places, there is lots of difficulties with shortage, staffing shortages, not having the right people, not being able to fill posts or people maybe leaving, you know, turnover of staff as well, and I guess that I was aware of that while I was in Muckamore, that, often, there weren't as many people in places you would have liked to have been, or people, maybe, who should have been coming to consult, couldn't, because there weren't enough people on the ward, that they couldn't leave, for example, you know, so I think those were ongoing difficulties, that there weren't enough staff in post. And I guess the other comment I made was kind of reflecting about, because I was asked about, impressions or kind of what had come up while I was there, and I was aware that the things that I had been hearing, I suppose, from colleagues in my time in the hospital informally, was that, sometimes, because of

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the staff vacancies or absences, or whatever the difficulties were at any particular time, there weren't always the same -- the right number of people, you know, in a ward that you would have hoped that should have been there, and the impression I had was that that meant that, sometimes, you know, people were being left -- were having to kind of manage and do things that were maybe a little bit beyond what their experience or their role should have been, would have dictated that they would have been doing, yeah. 11:04

58 Q. You've referred, I suppose, to you hearing things from people?

A. Yes.

59 Q. In terms, I suppose, of your involvement with DBT or the implementation or reinforcement of those practices on the wards with staff, did that have any impact in terms of the staff shortages or issues that you have described on, I suppose, the effectiveness of what you were delivering and how that was reinforced for patients on the wards; can you speak to that at all? 11:05

A. I think it -- primarily, I mean, it caused practical difficulties sometimes. Sometimes, it was difficult to make a session happen or, you know, it was difficult for staff to be where they wanted to be because they might be filling a gap somewhere else or being called to do something else, you know, so things don't always run just exactly the way you would like them to when that's going on, and I think that was the main effect that I was aware of myself. I think the other things

were just second- and third-hand kind of information that I was hearing.

60 Q. Thank you. And then you refer to the culture on the ward being dependent on the staff that were working there, and you've said in your statement that you didn't witness any poor practice yourself, but, you know, there certainly were things that could have been done better. So when you say the culture of the ward depended on what staff were working, what do you mean by that? 11:06

A. I think just -- I think just that, obviously, everyone has their own kind of styles and their own skills that they bring with them, and so, you know, that some members of staff in particular, I think I'd spoken about in my statement, that I felt did a particularly good job and brought lots of compassion and professionalism to what they did, and sometimes there was lots of that and sometimes there was a little bit less of it. Sorry, I'm finding it hard to -- 11:06

61 Q. Well, if we -- 11:07

A. -- put that into words.

62 Q. Sorry for cutting across you. I suppose if we focus then on, again going back to my previous question, the impact the different staff on the ward had on the culture, specifically focused on your work and how DBT skills were reinforced with patients on the ward; are you referring to that, I suppose, in terms of culture? 11:07

A. I suppose, yeah. I think it's probably quite a subtle thing, and it's just that, you know, some people

were -- are more tuned in and aware of those, you know, the DBT skills and the DBT teaching and trying to really reinforce and encourage and remind it, and other members of staff maybe wouldn't have kind of built it in as much or referred to it as much and maybe would have been just a bit more matter of fact, and so it's quite subtle, but, you know, I guess different people bring different things with them, if that is helpful. 11:07

63 Q. I have no further questions, but I just wanted, I suppose, to give you the opportunity if there is anything that you think you haven't covered that would be important for the Panel to understand about the psychology services that you provided at Muckamore? 11:08

A. Okay. I suppose the only thing that I would like to express, that I haven't really, is, I guess, the underlying reason why I made a statement to the Inquiry was really around, in the time that I spent at Muckamore being involved with that particular group of people, delivering that therapy, was that I really respected and appreciated the work that those people did. I found the people that I worked with to be very professional and compassionate and to do a good job, even when it was -- you know, obviously it's not going to be an easy job, that's okay, that's part of the package of going to work in an environment like that. That doesn't mean to say that it's easy. And I think what I observed in the time that I was there working with people was, I was seeing people who were maybe dealing with difficulties, and especially with all of 11:08 11:08 11:09

this, you know, these kind of difficulties coming out in the press and all the things that were happening while I was there, added an extra layer of difficulty and stress for people, and I suppose what I witnessed from the colleagues I worked with was that they experienced that in consult, or in private conversations they might express that in an appropriate way, get it off their chest, tell you what they felt, but appropriately and professionally, and then keep doing the job that they were doing in a compassionate and professional way, without, you know, taking things personally or, you know, changing, maybe, how they might act or treat people because of maybe how they might be feeling or what they might have experienced, and I think that I valued that in the people that I worked with and I wanted to be able to share that really, without wanting to detract from the seriousness of anything else that might have happened. 11:09 11:09 11:10

MS. BERGIN: Unless the Panel have further questions?

CHAIRPERSON: Thank you.

THE WITNESS WAS THEN QUESTIONED BY THE PANEL MEMBERS AS FOLLOWS:

64 Q. PROFESSOR MURPHY: Yes, I've got one question for you. It's been really helpful to hear about some of the psychological therapies going on, because an awful lot of what we've heard so far has been about medication as therapy. Could you tell us what other therapies were 11:10

being provided? So, for example, we understand there were quite a few men with harmful sexual behaviour in Sixmile, but we've seen nothing about whether sex-offender treatment groups were being provided.

A. Yes. I haven't been involved in that work myself, but I am familiar with it and I would use some of the resources in my own work in the community. So, as well as DBT, the other therapeutic work would have mostly happened on an individual basis, so it would be kind of tailored to meet the person's needs. And in terms of sexually harmful behaviours, there is a programme, again an adapted programme, that's been developed by colleagues in Northern Ireland, including in the Belfast Trust and in Muckamore, based on kind of established treatment approaches to working with people who have harmed people in a sexual way. So there is a programme there that has a series of modules that you work through with somebody to help them to understand their behaviours in the past and understand where the risks for those come from and understand how to manage those risks, how to change their behaviours and make changes in order to make sure, as far as is humanly possible, that those things don't happen again. So there would be a programme of work that can be -- and it has been delivered, usually on a one-to-one basis, and then, also, there would have been other kinds of one-to-one therapeutic work, some of it offence-related, some of it more about meeting the person's own needs for therapy and, again, on the

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understanding that, in order for somebody to be able to learn and understand their own behaviour and possibly to look at its impact on other people as well and to be able to manage their behaviour in the future, often that has to start with helping them to process their own very difficult experiences, often, and to deal with those in order to then be better able to regulate their own feelings and behaviours.

65 Q. PROFESSOR MURPHY: Was it your impression that there was sufficient psychologists to deliver other kinds of programmes? 11:13

A. I suppose I can only speak about the Sixmile unit, I can't really talk about what was going on elsewhere in the hospital. At the time that I was there, I think there weren't concerns about a shortage of hospitals at that point -- or psychologists at that point in time. In general, filling psychologist posts is a real challenge and turnover can be difficult to work with. But I think while I was there, I suppose once I joined the team and my colleague was there with me at the same time and our manager, so that kind of provided -- it felt like it provided a good level of coverage. I suppose in terms of, you know, therapeutic input and what else, I suppose you're asking about what else is there, you know, as well as medication, again it's not something I can speak about with any level of expertise, but I think the other side of, then, what was being delivered was around the behaviour team, so the PBS plans and the work that they did alongside

people understanding -- you know, trying to understand people's behaviours and put strategies and supports in place to help to kind of manage and help and improve their lives, so I think that that would be the other big area of work, and obviously those people were then often working with the other people that I described earlier, who maybe wouldn't benefit from DBT, who maybe is more -- whose disabilities are more severe.

PROFESSOR MURPHY: Thank you.

CHAIRPERSON: Dr. Maxwell? 11:15

DR. MAXWELL: No.

66 Q. CHAIRPERSON: Can I just ask some questions about numbers.

A. Yes.

CHAIRPERSON: And Professor Murphy has just touched upon the number of psychologists. What proportion of patients on Sixmile were you able to treat? Are you able to give us any idea? 11:15

A. In some ways, I would be better trying to go away and find that information out and provide it to you separately, if that's helpful. I mean, the Sixmile unit, I'm trying to think how many people would have been on it at any one time when we were there. So people going through DBT would have been, I suppose people would have only been a small proportion of the total people in the unit at the time, but then other people had already gone through it, you know, previously. So, I think that the hope -- the goal was that anybody there who could benefit from DBT would 11:16 11:16

have the opportunity to do that and would get that help available to them. In terms of exact numbers, we could certainly -- I could ask somebody to find that out --

67 Q. CHAIRPERSON: But you weren't limited --

A. -- and provide it to you, but I don't know. 11:16

68 Q. CHAIRPERSON: As far as you were aware, you weren't limited, as it were, by the number of psychologists available?

A. Not that I can remember.

69 Q. CHAIRPERSON: Okay. And when you start DBT, so would one refer to a course of DBT or a set number of sessions, or how does it...? 11:17

A. So I guess it's open-ended because it depends on the person's needs, just their level of dysregulation, how well you're able to kind of bring that kind of to a more manageable place. We would talk about cycles of DBT, which would be the number of times somebody goes through the skills group, so you might have somebody doing the one-to-one sessions, having the skills group, continuing one-to-one sessions after that, and then if you've achieved, I guess, what -- the kinds of change and progress that you would hope to achieve at that point, then they could move out of DBT and move on to other work or, you know, moving forwards, or they could continue with the one-to-one sessions and then complete another cycle of the skills group, so... 11:17 11:17 11:18

70 Q. CHAIRPERSON: So it was quite open-ended --

A. Yeah.

71 Q. CHAIRPERSON: -- in one sense?

A. Yeah, yeah. And again, given the nature of the population, often that idea of a kind of repetition and being able to go back over and reprocess learning can be quite important.

72 Q. CHAIRPERSON: But that was the other thing I wanted to ask you about, because presumably you would only be able to see patients, what, once a week? 11:18

A. Once a week for the one-to-one sessions, yeah, yeah.

73 Q. CHAIRPERSON: Yes. And how many days a week were you there? 11:18

A. I was there -- so my post was three days a week. At first, I would have been at Muckamore three days a week and then probably two days while I was involved in DBT.

74 Q. CHAIRPERSON: Right. So, once you have met with the patient and you have delivered your DBT session, 11:19 presumably you hope that those behaviours that you're trying to teach or to impart to the patient will be reinforced when they are on the ward?

A. Yes. So --

75 Q. CHAIRPERSON: Right. So, just tell us a bit about how 11:19 that worked, how you communicated to those who had been looking after the patient, what behaviours you would hope to improve?

A. Yes. So, the staff in Muckamore, DBT training had been delivered to a broad range of the staff in order then 11:19 that they would, you know, understand what the work was about and what you were talking about, if you were talking about a particular skill. So, we would have shared information with the ward about, for example,

what's the module we are working on at the moment in the skills group, what are the kinds of skills we are talking about, maybe shared handouts, we would have handouts and sort of visuals and reminders for the patients, and we'd try to share those with the wards so that the staff there were familiar with them --

76 Q. CHAIRPERSON: What does that mean in practical terms? When you say you are sharing something with the ward, is that through an MDT to do you be speaking to nurses on the ward or other staff -- 11:20

A. That would be to staff, go into the office, talking to the senior nursing staff there, maybe leaving material in the office, and it would be about really kind of trying to share information about, you know, if something comes up, you know, if there's an opportunity, could you be reminding this person, maybe this is a good time to practice this skill or reminding them about it or using the language that kind of refers back to their learning, to help to generalise the learning. 11:21

77 Q. CHAIRPERSON: In paragraph 38, you talk about constant staffing issues. For your therapy to have its best effect, presumably you need staff who understand DBT and know the patient?

A. Yes. So, for the best, I guess, environment, what you would want would be a stable staffing team so that there's good working relationships built up between the staff and the patients, so they know one another, build up some trust and familiarity and, also, that staff are 11:21

familiar with the treatment approach as well.

78 Q. CHAIRPERSON: So does it follow that if there are frequent changes of staff on a ward, that is going to inhibit, to some extent at least, the effectiveness of the DBT you're providing? 11:22

A. It has potential to, and I suppose the biggest concern would be about, you know, that information-sharing, whether -- is everybody hearing and thinking about that?

79 Q. CHAIRPERSON: Were you ever aware of it directly affecting your work? 11:22

A. I don't -- it never caused me a problem, you know. I suppose, let me just think about the nature of the effect. It wasn't something that caused me difficulty in my day-to-day kind of dealing with people. I suppose, though, what might have been then in the background would have been about, you know, not always knowing exactly how much reinforcement or kind of connecting back to the work might happen; you know, sometimes, probably, it would be better than others, would have been my expectation. 11:23 11:23

CHAIRPERSON: Unless there are any other questions arising, Dr. Byrne, can I just thank you very much indeed for coming to assist the Inquiry. I think you're the first psychologist we've heard from. No, I'm being corrected, as ever, by Dr. Maxwell on my left, but that has been illuminating, and particularly for me, about DBT and how that works. So can I just thank you very much for coming along to assist the 11:23

Inquiry and you can now go with the Inquiry Secretary.

THE WITNESS THEN WITHDREW

CHAIRPERSON: We'll take a short break. I think you've got some statements to read? 11:24

MS. BERGIN: Yes, there are two statements.

CHAIRPERSON: Okay. Well, let's take our morning break, a quarter of an hour, and then we'll come back in. Thank you. 11:24

THE INQUIRY ADJOURNED FOR A SHORT PERIOD AND THEN RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you. Yes.

MS. BERGIN: Thank you, Chair, Panel. There are two statements to be read: the Witness H471 and then H137. 11:48

In respect of H471, a Restriction Order was granted on 26th of April 2024 in respect of their evidence, providing that their cipher will be used, and the statement reference is STM-211. The statement is dated 12th March 2024. 11:48

I may summarise some portions of the statement, but, of course, if there's any particular aspects that the Panel would prefer me to read in, please indicate. 11:49

CHAIRPERSON: Yes. Again, we have just got to remember we are a public hearing and obviously the public must hear as much as is relevant.

MS. BERGIN: Yes, certainly.

STATEMENT OF H471, REFERENCE STM-211:

MS. BERGIN: "I, H471, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement. 11:49

My connection with MAH is that I was a daycare worker Band 5 and then a senior daycare worker Band 6 at the hospital. I am now retired. The relevant time period that I can speak about is between 1980 and 2015." 11:49

The witness then describes how their association with Muckamore began in 1979 during a youth leadership course. They began working at Muckamore in 1980 and worked there for 35 years, until their retirement. 11:50

Picking up at paragraph 5, overleaf:

"Initially I worked in the male and female workshops as an instructor. I then worked as a daycare worker. I 11:50 was temporarily promoted to senior daycare worker Band 6 in 2000, this became my permanent position in 2001.

Throughout this role, I managed the Portmore and 11:50 Portview units in MAH and I then moved to the Work Skills Department, until my retirement. I retired from my role in 2015 as I was asked to reapply for my post due to the restructuring and downsizing at MAH.

During my time at MAH, I also acted as a local trade union representative for the Northern Ireland Public Service Alliance, NIPSA. I mainly dealt with general queries such as annual-leave issues. I was involved with two trade union cases in the 1990s. These two cases involved alleged physical assaults on patients by MAH staff members H578, H*778*. These two cases were dealt with by the courts and the individuals never returned to MAH. These alleged incidents of abuse occurred on the wards and, therefore, I did not witness the incidents directly. My role was to speak to the staff member, record the incident and accompany the staff member when they were suspended by MAH, pending an investigation by MAH and the Police Service of Northern Ireland. After this, the full-time trade union representative became involved and I had no further involvement. 11:51 11:51 11:51

Due to not having adult daycare centres in the community, many people with learning disabilities who were living in the community were transported on a daily basis by bus to MAH and attended the male and female workshops. In the early 1980s, MAH patients also attended the Daycare department daily." 11:51 11:52

The witness then goes on to describe the different rooms, such as painting or contract rooms, where patients did work, including packing fruit or printing

labels.

Continuing overleaf, paragraph 8, the witness describes the contract work:

11:52

"MAH had an employment officer who organised the contract work."

The witness describes how patients were paid for their work, participated in non-work activities also, 11:52
including discos, swimming and walks, and that patients also worked in the garden, growing vegetables, to be sold to the public or used at Muckamore.

The witness then describes the culture at that stage in 11:53
the workshops in the 1980s as very formal, with staff being referred to as "Mr", but that staff morale was high and that patients took pride in their work and looked forward to it.

11:53

The witness continues at paragraph 10:

"In the 1980s, I completed a wide range of courses at MAH. I was also MAPA-trained. I completed courses including a social care certificate course, a National 11:53
Vocational Qualification (NVQ) in management, interview and selection training, back care, food hygiene and a Level 1 and Level 2 learning disability football course."

The witness then describes workshop services becoming the Daycare department in the 1980s, which they say led to a timetabled system of patients moving between buildings. They describe patients then having individual daily timetables, moving between departments, and a variety of activities, including arts and swimming and education programmes, being provided to patients. 11:54

The witness then describes how they worked in the Leisure and Recreation department, before moving to the Intensive Support Unit department. The witness then describes various changes to the use of buildings on the MAH estate. He worked in the Intensive Support Unit for years, before moving to Portmore, which had different activity rooms and an elderly care room. 11:54

Picking up at paragraph 13:

"H836 was the initial daycare manager. I cannot recall the dates. When H837 took over as daycare manager - I cannot recall the dates - from H836, the system changed for the better, providing a Daycare department suitable for patients' needs. New activities were introduced, such as an education programme, an artist in residence and a music therapist. The set groups of patients were a mixture of patients from different wards. There was a good working relationship between the daycare staff 11:55

and the wards.

I became the acting senior daycare worker on a temporary basis in July 2000. Fourteen months later, I was made permanent in this position on 11th September 2001. I was responsible for the day-to-day running of the Portmore and Portview units, the welfare of the patients, allocation of duties within the Daycare department, staff supervision, petty cash, managing annual leave, attending meetings, assisting with the resettlement team, patient meetings and assisting with the health promotion team, such as supporting smoking cessation. 11:55 11:56

I was responsible to both the Daycare Manager, H77, and the Deputy Daycare Manager, H299. My fellow senior daycare workers were H727, H362 (deceased) and H466. In total, we had approximately 50 staff within the daycare team. This included full-time daycare staff as well as nursing assistants. In my opinion, all of the staff were very good at their jobs. 11:56 11:56

In my role as senior daycare worker, I attended weekly senior meetings. These were comprised of the four senior daycare staff members mentioned above, the Daycare Manager, H77, and Daycare Manager, H299. At the weekly meetings, we discussed staffing levels, training, schedules, rotas, and we were provided with any general updates on MAH by H77. This would include 11:57

issues such as changes to staffing on the wards and the current situation in MAH. As senior staff, we informed the meeting attendees of any outings planned within our department. Staffing levels were often dealt with due to day-to-day issues arising, such as staff sickness. 11:57
We discussed if any members of staff required training, such as the five-day MAPA course or any first-aid training. A weekly rota was constructed for the senior staff to start duty at 8 o'clock in the morning in order to answer telephone calls from staff reporting in 11:58
sick or carer's leave, as this gave us time to organise each other's department."

The witness then describes a variety of activities that the patients in Portmore and Portview participated in, 11:58
including speech therapy, swimming, group outings, education classes from the Belfast Metropolitan College, Young Enterprise Scheme, NVQ in car washing, cookery class. And the witness describes a very positive culture in the Daycare department, describing 11:58
the daycare staff as "the unsung heroes".
CHAIRPERSON: Yes, and also describes the various sort of outings that the patients were able to enjoy.
MS. BERGIN: Yes. For completeness, those include the Lagan River Lookout, Belfast City Hall and Belfast 11:59
Castle and then going to Tesco to pick out ingredients for cookery.

The witness then describes a summer scheme, a range of

activities including fancy dress competitions, summer barbecue, annual art awards, a petting zoo, a local cinema trip, World Cup trips and having Italian-themed nights for the World Cup and staff decorating the gym.

11:59

The witness continues at paragraph 19:

"When a patient was admitted to MAH, the patient was assessed on their ward and a recommendation was made for daycare. A pen picture was received by the 11:59
manager, or deputy manager, who would discuss with the senior daycare workers to ensure that the patient was appropriately placed in the daycare system. I would receive a pen picture of the patient. This would provide the daycare worker, and myself, with the 12:00
necessary information regarding the patient's admission to the department. By using the information provided, I could place the patient in the appropriate room for activities based on their unique skill set and needs. For example, if the patient was of high ability from 12:00
the Cranfield or Sixmile wards, they would go to the Work Skills Department, whereas the patients with more profound needs would go to Portmore or Moyola.

The pen picture would inform us if any patients 12:00
displayed challenging behaviours, such as absconding, and they would be accompanied to daycare with their one-to-one nursing assistant. If a forensic patient was admitted and was attending Work Skills, the daycare

would be discussed at the ward-round meeting. This would include what measures were needed to ensure everyone was safe. The patients displaying challenging behaviour would be supervised one to one and we rarely had any issues. We were informed if patients had specific vulnerabilities such as a risk of self-harm, choking risks or eating non-food items. Daycare staff would then adjust the activities for the patient involved to suit their needs and reduce the risk of the patient being harmed. 12:01

Each daycare worker was responsible for five to eight patients. At the end of each day, the daycare staff would have their own set of notes to compile on each patient. The notes were kept in an allocated filing cabinet under lock and key, with each daycare worker being responsible for their own cabinet. Daycare management and the senior daycare workers had access to the filing cabinet. These daily notes would assist with the patient's six-monthly report and annual review. The annual report reviewed the patient's general behaviour, the patient's participation with activities and their attendance at daycare. The daycare workers would then present patients' annual reports at the ward annual review meeting to the ward manager, named nurse, consultants, social workers, parents or guardians. 12:02

There were weekly ward-round meetings. This enabled

information to be shared between the daycare staff and the ward staff. There were specific ward-round meetings for each ward. Consultants, social workers, daycare staff, dieticians, physiotherapists and parents or guardians of patients would all be in attendance at these meetings. I was responsible for representing the Work Skills Department and relaying important information regarding their activities. I think the meetings were more effective when a daycare worker attended. This enabled information regarding the day-to-day running of the Daycare department to be shared with the ward staff. 12:03 12:03

I operated an open house and a transparent policy when it came to involving patients' families. I welcomed families to visit patients at daycare. If families chose to attend, I explained what was going on and the activities their relative was participating in. I offered them a cup of tea and built a rapport with them. 12:03 12:03

There were still challenging days working at MAH. This includes those patients who had limited or no communication skills. They might have communicated by physically hitting out at staff members and displaying generally challenging behaviour. Most of the time, the staff used de-escalation techniques, such as talking calmly with the patient to rectify the situation. I felt the daycare staff went the extra mile to calm 12:04

patients. You got to know the patients over time. There were a few incidents that required physical intervention within the Department and I feel that these were dealt with appropriately. For instance, one patient was calmed by giving them a cigarette. 12:04
Whenever de-escalation techniques failed, staff had to rely on MAPA training, but it was used very rarely, in my experience, in daycare. I ensured that all of the daycare staff attended a five-day MAPA training course in physical intervention of patients and first aid 12:04
training.

After any incident where physical intervention was utilised, the daycare staff involved would complete a form. This form included who was involved and what 12:05
happened. This form would then be sent to the administrative team at MAH.

I felt supported within my job role by my colleagues and supervisors, H299 and H77. An example of this 12:05
support was evident in carrying out my plans to redesign the layout of the Portmore building. In or around 2005, Portmore was a shared building with children's services and we needed to separate the forensic patients due to safeguarding concerns as they 12:05
could easily come into contact with the children in the building. Staff Nurse H832, and H823, Nurse Manager for Children's Services, agreed with my idea to redesign the layout of the building by swapping rooms.

After the redesign, the forensic patients from the Sixmile Ward were separated from the children via a locked door and the two categories of patients had separate bathrooms and separate entry and exit points.

12:06

I moved to the Work Skills Department in 2007."

The witness then describes the various rooms in the Work Skills Department, including an art room and workroom and activities for patients, including swimming, cooking, patient contract work, which included packing, and the money was paid to the Belfast Trust accounts.

12:06

"The patients who attended Work Skills came from the Sixmile, Cranfield men's and Cranfield women's wards. They were patients who were very capable of making their needs known and carrying out the tasks in work skills. Staff carried a personal alarm on their wrists and these alarms were tested daily. This system within the daycare area meant if one staff member needed assistance with a patient, they would sound their alarm and staff went to assist. Designated staff from Portmore and Moyola attended when the alarm went off in the Work Skills Department. There were only a few occasions when the alarm went off. These incidents were usually dealt with by staff using de-escalation techniques. The other staff arrived as back-up and were stood down when not needed. Sport played a big

12:06

12:06

12:07

part in Work Skills Department. We had patients who were Northern Irish and British World Pool Champions."

And the witness then goes on to describe coaching football at Muckamore, the Muckamore team winning the IFA Disability League six times in a row and also winning the Coca-Cola Cup. 12:07

"From 2011 until I retired in 2015, I organised football matches against the Estates Team comprising of the plumbers, joiners and electricians. They called themselves 'the Docket Boys'. They joined our training sessions every Thursday night. It was one of the best experiences I had at MAH to see the interaction between the patients and the Estate staff. This was something special. The friendship, the banter between the patients and the maintenance staff was unbelievable. An annual match was organised between Abbey Football Club versus the Docket Boys." 12:08 12:08

The witness then continues and describes arranging football trips at local clubs who came and played against the patient teams and staff teams. They brought trophies to Muckamore, players attended Muckamore. The witness then describes other activities for patients, including a Grease musical that was put on by staff and patients, golf lessons, and patients and staff making golf and football training areas at Muckamore and maintaining those. 12:08

The witness continues:

"I was also part of the audit group who carried out the audits on the wards and the Daycare department. We worked in teams of two or three and were allocated a ward to audit. On the ward, we randomly selected and inspected patient care plans. The selected ward would be informed of the time and date of the audit. The auditor would then request six patient care plans. The auditor would check each care plan was signed and dated, all notes were up to date, all of the patient's medication was recorded, the pen picture was present, notes for ward-round meetings were present and the patient's annual review notes were present. If the ward had failed to provide any of these documents, the ward would be given a set time to address and update the patient's care plan. I was accompanied by a Staff Nurse on the audit inspections. 12:09 12:09 12:09

I was part of a multidisciplinary team (MDT) that worked on the discharge and resettlement of patients from 2009 until 2012. This MDT involved ward consultants, physiotherapists, speech and language therapists, a dietician and a community social worker. The team reviewed individual patient's needs and tailored the resettlement plan to the individual patient. The social worker was the main point of contact for relatives during resettlement. 12:10 12:10

My role was to assess the daycare facilities with regard to the patient's needs at the proposed resettlement facility. I ensured the facility had equal or enhanced daycare facilities as provided at MAH. This work included long meetings with a lot of planning tailored to the patient's needs. I was then provided with action points to follow up on from each meeting, which resulted in a lot of additional hours of work outside the meetings. 12:10 12:11

Once there was an identified resettlement option, I would visit the facility to ensure the placement was appropriate and to identify if any adjustments were needed. I made key recommendations to the resettlement plans. These recommendations were based on the patient's unique skill set and capabilities. For example, patients with profound needs from the Portmore ward enjoyed art and painting. I had to ensure the placement was suitable for the patient and that the family or guardians were also happy. 12:11 12:11

There were practical barriers to the resettlement of patients. The main barriers were funding issues and the patients' parents or guardians wanting the patient to remain in MAH. I remember that there was a resettlement placement set up in a new residential area in Coleraine and there were objections from the neighbours. This was quickly sorted. The resettlement 12:11

plans were sometimes met with a great deal of opposition from the local community. However, most of the resettlement of patients went very well. None of the resettlement plans went ahead without everyone involved being satisfied with the plans and all the boxes being ticked.

The daycare staff went above and beyond to support patients. For example, staff would bring in presents for the patients for their birthdays and Christmas. They would stay late to take patients on trips to the pantomime, ice hockey and concerts. 12:12

During my years as a senior daycare worker in MAH, I always felt supported by my colleagues and management staff. I felt comfortable to raise complaints when needed as I had a good working relationship with H299 and H77. I reported any issues or complaints that arose relating to Work Skills. These were recorded in a complaints book. H359, Assistant Director of Hospital Services, and H838, Director of Hospital Services, would visit the Daycare department unannounced. We operated an open and transparent culture in the Daycare department. H359 knew everyone, patients and staff names. Visits to daycare were quite a regular occurrence by senior management on site. H359 and senior staff onsite would attend all functions. Invitations were sent to the Belfast Trust Board and other senior staff in the Belfast Trust to 12:12 12:13 12:13

attend Harvest and the Christmas carol service, but they never turned up or replied to the invitation.

I felt there was a clear cultural change towards the end of my time at MAH. The number of patients reduced and there were staff shortages from 2013. Nursing assistants were taken out of daycare to be sent to the wards and this left the Daycare department short-staffed. With new management in place, staff morale was low. I cannot recall who said this, but I remember a quote where someone said, 'This is a hospital, not a holiday camp'. Obviously, they did not think that MAH was the patient's home and was just a hospital. A lot of changes happened which, in my personal opinion, were unnecessary. These changes included stopping the evening activities, such as the disco, the evening clubs run by volunteers, and stopping the Sky television, a subscription in the wards which patients had paid for themselves. The Helping Hands Club volunteers had been running the club over 40 years and had to close. A further example of the culture shift was an instruction from management to only put up the wards and daycare Christmas trees on a certain date. Patients looked forward to all Christmas activities as they enjoyed helping to decorate the wards and the Daycare department. Previously, wards would have fun by competing as to which ward had the best Christmas decorations, but this all to stop because of an infection control policy. I personally

12:14 12:14 12:14 12:15 12:15

feel the new management had no idea about the culture or the running of MAH; they only had one agenda, which was to close it.

I was not involved with the RQIA inspections. There were no CCTV cameras within the Daycare department when I worked there. There was nothing else I was uncomfortable with at MAH." 12:15

The witness then goes on to state they don't wish to give evidence, and there is a signed declaration of truth, and that concludes the statement. 12:16

CHAIRPERSON: Thank you. Then, it's H137?

MS. BERGIN: Yes.

CHAIRPERSON: Are you all right to keep going? 12:16

MS. BERGIN: Yes, yes, no, absolutely. H137, yes. Similar to the previous statement, Chair, you also granted a Restriction Order in respect of this witness's evidence in the same terms; namely, that their cipher would be used, and that's Restriction Order No. 57, granted on 26th April 2024. 12:16

The reference for the statement is STM-225, and H137's statement is dated 9th of April 2024.

<u>STATEMENT OF H137, REFERENCE STM-225:</u> 12:16

MS. BERGIN: "I, H137, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement.

My connection with MAH is that I worked at MAH from 1995 until 2013. During this time, I held positions as a Nursing Assistant, A Grade, 1995 to 1997, Ward C9; and 1997 to 2002, Movilla A; a Band 5 Staff Nurse, 2005 to 2007, Moylena; and 2007 to 2011, Cranfield Men's; a Band 6 Deputy Manager, 2011 to 2012, Cranfield female; and a Band 7 Ward Manager between 2012 to 2013, Moylena. 12:17

12:18

The relevant time periods that I can speak about are between 1995 and 2013, but, unfortunately, due to the time that has passed since my employment at MAH, I am not able to recall much of any specific information during this period. 12:18

I first started working at MAH in 1995 when I was 18 or 19 as an A Grade Nursing Assistant, which is the equivalent to a Band 3 today. MAH were advertising for care assistants in the local newspaper, as I recall, and I had a couple of friends working there at the time who I knew through football, so I thought I would apply. At this far removed, I cannot recall any details or specifics regarding the recruitment process and what that consisted of, but I do recall there was an interview. I do not recall any information about my induction or the induction of staff generally at MAH. Prior to joining MAH, I did not have a specific interest in a career in nursing. 12:18 12:18

The first ward I worked on at MAH as an A Grade Nursing Assistant was C9 Ward. I recall the patients on this ward had profound learning difficulties and would have required a lot of assistance with their personal-hygiene care as well as assistance during meal times, such as cutting up their food and feeding. At this far removed, I do not recall any of the patients' names or their medical conditions. I believe my line manager was H859. My main memory of C9 is of going on long walks in MAH grounds and outside MAH grounds during the summer and sometimes taking a football out with some of the patients. I would have informed the nurse in charge if we were going for a walk. I do recall great emphasis was placed on keeping patients occupied with activities throughout the day. I cannot, at this far removed, comment on the question of what the culture was like. I do not recall any incidents of aggression between patients and staff or staff and patients during my time on C9. I do not recall any information on complaint procedures. 12:19 12:19 12:20 12:20

Staff would have been allocated certain tasks throughout the day, such as escorting patients to daycare and assisting with their personal care needs. I believe I was usually allocated a patient group of no more than four patients to assist with personal care in the mornings and during meal times. In 1997, I moved to Movilla ward as an A Grade Nursing Assistant, 12:20

although I cannot recall the reasons for this move or whether it was something I requested."

The witness then goes on to describe the atmosphere on Movilla as being good for both workers and patients and, overleaf, they say that they do not recall anything negative happening on the ward, nor who their line manager or supervisor were, and they described the care they provided as being similar to the care on the previous ward. 12:21

The witness then continues:

"I left MAH around 2001/2 to begin my nursing training at Queen's University Belfast. I graduated as a learning disability nurse in 2005 and returned to MAH that year as a qualified Band 5 Staff Nurse on Moylena ward, which was known then as M4. I had to apply for this role and had induction training upon my returning. My responsibilities included following the nursing process of assess, plan, implement and evaluate. I used the nursing model of Roper, Logan & Tierney. I believe I had a six-month supervised period from other senior nurses. 12:21 12:21

I recall the patients from C9 were transferred to Moylena due to its closure, but I cannot recall why it closed. At this far removed, I cannot recall how this was communicated to me or how this was communicated to 12:22

patients. On Moylena, I would assist patients with their personal hygiene needs and with eating during mealtimes. Band 5 nurses would have been in charge of the ward at this time, but I do not recall being in charge in my early days as a Band 5 nurse in MAH. At this far removed, I do not recall the names of any of the nurses in charge of the wards. There were always two trained nursing staff on shift and the more experienced of the two would have been put in charge and would have allocated work through allocation sheets. 12:22 12:23

In answer to the question about whether I felt supported in MAH, I would say I did feel supported throughout my time at MAH and at each level of management. You could have asked for advice from senior management if you felt you needed it, but, given the passage of time, I cannot recall specific occasions when I had to ask for advice. The managers who I felt supported by and that I remember were H859, H823, H377 and H214. I received clinical supervision during my time as a Staff Nurse, but I cannot remember much of the specifics around this. It was likely on a one-to-one basis with my line manager, such as H823 or H377, but I cannot recall exactly what it consisted of. 12:23 12:23

In answer to a question about the 'culture of management', I am unsure what the word 'culture' means in this context. I can say, though, I remember that I

regularly talked to management and I always felt that I could speak about or report anything I may have been uncomfortable with, but I do not recall any specific occasions when I had to do so.

12:24

I did not have any issues reported to me by staff during my time as a Band 5, 6 or 7, that I recall. I was in the Band 7 post in Moylena for a very short period of time, 2012 to 2013. It is difficult to recall without access to documents, but I do not 12:24 remember there being any issues reported to me or witnessed by me which may be relevant to the Inquiry's Terms of Reference.

As far as I can remember, I was always clear on what 12:24 the purpose was for each patient's admission. Staff would have had the patient's notes to read as well as family members providing information on their relative. There would have also been overlaps in the shifts between night staff and day staff, particularly when I 12:25 was on C9, and a handover would have been given by the previous nurse in charge. There would also have been contact with community staff and social workers regarding admissions, particularly so in the case of emergency admissions. I always felt the reasons for 12:25 admission were well-communicated by me to the other members of the nursing staff and the next shift.

Other than providing additional information to assist

with the care of their relatives, I do not recall any specific instances of family involvement with patients on the ward. I recall in general terms that families would have visited patients on the ward and I would provide an update on their care and how they were doing. Some family members would have taken patients for a drive and others would have spent time in the visitor rooms. I do not recall receiving any complaints or queries from patients' families. 12:25

I was made aware of each patient's skills in the same way I was made aware of that patient's reason for admission, through their patient notes and at handovers or being present during admission. I cannot recall anything further in this regard. 12:26

In respect of a patient's challenging behaviours and mental health needs, I would have been made aware of these in the same way as I have referred to above. If a patient's admission was planned, the information would have been available in advance and staff would have be aware of any challenging behaviours. However, if it was an urgent admission, information was less likely to be available. In these circumstances, as answered previously, if more information was required, telephone calls would have taken place with community workers of family. A lot of the patients admitted to MAH during my time there would have been known to staff, so we were likely to already be aware of them, 12:26 12:27

but it did depend a lot on the type of admission.

With regard to developing care plans, this was a standard part of the nursing process. I would have followed the care plan prepared for the patient and ensured it was implemented as best as possible. Daycare staff would also have been involved in developing care plans, as well as the multidisciplinary team, which was made up of speech and language therapists, physios and consultants. Each patient's care plan would have been discussed at weekly MDT meetings, which I participated in. In my position as a Band 6 and Band 7, I had less involvement with the implementation of care plans as I would have managerial tasks to tend to on a daily basis. 12:27 12:27 12:28

With regard to the kind of treatment plans patients had at MAH, I recall that we followed what was taught to us by our nursing models, such as the Roper, Logan & Tierney model, mentioned earlier in my statement, which is a theory of nursing care based on activities of daily living. This meant including as many daily activities as possible as part of a patient's care plan to look after their physical health on a daily basis. 12:28 12:28

I cannot recall much detail on the medications that would have formed part of a patient's treatment plan, as this would have been decided by consultants on the wards.

With regard to the risks each patient might potentially pose to themselves and others and their vulnerabilities, staff would have been aware of these through patient notes and possibly through their involvement at admission stage. I recall some patients would have had altered diets if they had allergies or posed a high risk of choking and recommendations would have been provided by a dietician for this. Staff would have also found out information through the weekly MDT meetings, but unfortunately, at this removed stage, I cannot recall how vulnerabilities were assessed or by who. Beyond my general responsibilities as a nurse, I cannot recall what role I had in recording incidents or mitigating against resulting risks. 12:29 12:29 12:29

I recall mealtimes at MAH were supervised by a number of staff walking the floor of the dining room during all meals, but I cannot recall how many staff there would have been at a time. I do not recall any issues in relation to mealtimes or choking. 12:29

I believe the term 'restrictive practice' did not come into common usage until after I had left MAH in 2013. However, it was clear to me at MAH what restrictive practices were available to be used, but I cannot recall much of what was used during my time. I cannot say what my assessment was of how well restrictive 12:30

practices were used and recorded, but I do remember that, if it had to be used, it would be recorded in a patient's notes, and there was guidance to be followed for recording them in separate books as well. I do not recall having to complain about or receiving complaints from any members of staff or patient family members in relation to restrictive practices. 12:30

A lot of doors in certain wards would have been locked at all times, which is a restrictive practice in itself. I had training on restrictive holds and I was required to complete yearly refresher training. I would have been trained in these holds when I joined MAH as a Nursing Assistant and would have followed my training on when to use them. In my early days as a Nursing Assistant, recording the use of restrictive holds was done by a nurse manager and would have been recorded in a patient's daily notes as well as in separate reporting sheets. 12:30 12:31

My initial training at MAH helped me with managing patients who were distressed. I was taught to use de-escalation techniques in the first instance to avoid having to use any restrictive practices. Something that always sticks in my head is that restrictive practices were always a last resort. I would have been in contact with consultants on the ward if a patient became distressed and would have taken their advice on how best to manage their distress. I do recall pro re 12:31

nata, PRN, medication being given to patients, such as pain relief or epilepsy medication. Any PRN administration would have been recorded on a patient's notes.

12:32

I do not recall much about how decisions on restraint and seclusion were taken, but I believe they would have ultimately been taken by a medic, who would have been consulting with the nurse in charge at the time. I do remember making some calls to medics when I was a Band 7 to get an opinion on what to do if all methods of de-escalation did not work, but I cannot recall the specifics of the incidents the calls related to.

12:32

As I have mentioned, the use of restraint and seclusion was recorded in a patient's notes as well as in separate incident books. If I was the nurse in charge, I would have likely made those recordings unless delegated to another nurse. I do recall there was a document called a Seclusion Care Plan that started if a patient was placed in seclusion or if any physical holds were used on them, but I cannot recall any further details about this or specific examples of the use of restrictive holds. I do recall having to use restrictive holds on patients at times, but I do not recall this happening on a regular basis. The use of PRN sedation, restraint and seclusion on the wards was monitored on a weekly basis through discussion and at the MDT meetings, from what I can recall.

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12:33

There was no CCTV in operation during my time at MAH, either inside MAH or outside of it, so I have no information on its use.

12:33

With regard to patient discharge and resettlement, I would have been made aware when patients were ready for discharge or resettlement at our weekly MDT meetings. I recall there would have also been a planning meeting in advance of any discharge or resettlement, which was 12:34 attended by the MDT, and I would have contributed to that if I was in charge of the shift or if I was the patient's named nurse. At a basic level, I recall preparing medications for patients in advance of being discharged. 'Resettlement' as a term did not really 12:34 start to be widely used until after I had left MAH, from what I can remember. I cannot recall any specific training being provided or required to assist with the discharge process, but I would have felt adequately trained to assist and never asked for any additional 12:34 training.

In my role as a Band 5 Staff Nurse, I recall delegating aspects of care to Bands 2 and 3, based on their experience caring for patients and how long they were 12:35 in the roles. So far as I can remember, I assured myself that unregistered staff were completing tasks adequately by observing them while working alongside them. Cranfield ward was an open ward, so I could have

supervised staff on the ward from the office, which was in a central position in the ward, with good observation from inside the office.

A patient's care plan and reassessment of their activities of daily living was reviewed either every three or six months and any changes made that were required. The physical needs of patients were assessed and managed through the general nursing process as well as at the MDT meetings. I do not recall ever examining patterns of behaviour for individual patients. 12:35 12:35

I struggle to remember the therapeutic interventions on a day-to-day basis. I do recall I would have taken patients for walks to the football pitch or to use the onsite swimming pool. One or two evenings a week, a few patients would have went to the local town to do some shopping. 12:36

I do recall having protected time for training CPD. As a nurse, I was expected to do a certain amount of CPD each year. 12:36

In my position as a Band 6 and 7 nurse, I recall I would have overseen that the care on each shift was safe, effective and compassionate, by observing the staff members providing that care. As mentioned earlier in my statement, as a Band 6 I would have been more present on the wards and worked alongside staff 12:36

nurses and care assistants. However, as a Band 7, I would have spent more time in the office doing administration work. I recall starting to carry out one-to-one supervision with staff when I was Band 6 and 7, although I cannot recall any further specifics. 12:37

As far as I can remember, there were adequate staff on the wards to deliver everything on patients' care plans. There would have been times when a staff member would have called in sick, but not in such numbers that 12:37 I would have considered there to be a staff shortage.

There was sufficient input from the Allied Health Professionals and psychologists, as far as I can recall, as I would have seen them regularly on the 12:37 wards. There was also a physiotherapist based on site at MAH during my time there, although I cannot recall their name. There were also speech and language therapists that would have worked closely with the nursing staff. I cannot recall their names. There was 12:37 also a social worker based on site who would have also worked closely with nursing staff on a regular basis. I cannot recall their names. This was the same across both Cranfield wards, but I would have seen more of certain AHPs on one ward compared to the other, due to 12:38 the particular needs of the patients.

Nursing records and care plans were regularly audited, as far as I can recall, although I cannot recall how

regularly. I also cannot recall what feedback was received following those audits or what changed as a result.

In relation to Datix reports, I cannot recall how these were reviewed at ward level. I do not recall whether I ever reviewed them. 12:38

In relation to RQIA inspections, I can remember there being both announced and unannounced visits, but I do not recall what aspects of care they would have been reviewing during those visits. I cannot recall any particulars or how these visits were prepared for. 12:38

It is hard for me to say how often I saw management and/or Trust Board members walking the wards. I could not give details on how regular of an occurrence this was, but I would have seen them on the wards from time to time. I do not recall the details of any discussions I had with senior management when they walked the wards. 12:39 12:39

I do not recall there being any wards changing or merging during my time at MAH, although Cranfield opened in my time there. 12:39

I worked at MAH until 2013. The reason I left was that I wanted to work in the community and I have held community-nurse positions since 2013. Unfortunately, I

have found it very difficult to recall specific details from so long ago, especially without access to documents from when I worked at MAH, such as patient records. Where I have not had a clear and reliable recollection of something, I have not wanted to guess or speculate." 12:40

The witness then outlines their preferences about giving evidence and there is a signed declaration of truth. 12:40

That concludes the evidence for today, Panel.

CHAIRPERSON: Okay. Well, thanks to H137 and H471 for those statements, and thank you very much indeed. 12:40

All right. So, we are next going to meet, I'm afraid, next Monday, and again, apologies that we haven't been able to sit more this week, for reasons that I explained earlier. Okay, thank you very much. See you on Monday. 12:40

THE INQUIRY ADJOURNED UNTIL MONDAY, 13TH MAY 2024.