MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 13TH MAY 2024 - DAY 81

81

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

APPEARANCES

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

FOR DEPARTMENT OF HEALTH:	MR. ANDREW MCGUINNESS BL MS. EMMA TREMLETT BL
INSTRUCTED BY:	MS. CLAIRE DEMELAS MS. TUTU OGLE DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DWF LAW LLP
FOR PSNI:	MR. MARK ROBINSON KC MS. EILIS LUNNY BL
INSTRUCTED BY:	DCI JILL DUFFIE

INDEX

THE INQUIRY RESUMED ON MONDAY, 13TH MAY 2024 AS FOLLOWS:

CHAIRPERSON: Right, please take a seat. Thank you very much.

Right, Mr. McEvoy, can you just tell me who is hidden behind the curtain?

MR. MCEVOY: Yes, Chair, Panel. This morning we have a witness who is A12, and we have two supporters in the form of a counsellor and another supporter who is a friend.

CHAIRPERSON: Right. A12. Before you're sworn in, I'm just going to say it's good that you've got supporters with you, and I'm pleased to see that, but it is important you don't speak to them about your evidence at any point at which we take a break until you've completely finished. All right? Thank you for coming along to assist the Inquiry and you'll now be sworn.

A12, HAVING BEEN SWORN WAS EXAMINED BY MR. MCEVOY AS FOLLOWS:

MR. MCEVOY: Good morning, A12.

A. Morning.

1 Q. We met a few moments ago. As you know, my name is Mark McEvoy and I'm one of the Inquiry counsel and I'll be taking you through your evidence this morning.

You have in front of you, A12, you have in front of you

a folder containing a statement dated the 28th March this year?

A. Yes.

2 Q. It's 90 pages in length. Do you recognise it?

A. Yes. 10:06

3 Q. And do you want to adopt then that statement as your evidence to the Inquiry?

A. Yes, indeed.

4 Q. Well, following on from that statement then, I just want in general terms to give Core Participants and 10:06 indeed the Inquiry an idea of what you tell us in this statement. At the outset you tell us that you were employed at Muckamore between 1985 and 2023. You had a career there as a student nurse, a Staff Nurse, a Ward Sister, and out-of-hours co-ordinator. You've been 10:06 able to play a significant part in changing lives with people with a learning disability and their families. You then go on to describe not only your personal connection and fondness for nursing, but also your family's connections with nursing, going back a number 10:06 of generations. And also then your own personal proximity and experience of Muckamore.

You then tell us that it wasn't your original intension to work at Muckamore and that you had an ambition to 10:07 work for British Airways, but then you go on to say that you decided to pursue a career at Muckamore as you realised you could be a trained nurse by the time you were 21 and that given your upbringing you already

enjoyed being around people with a learning disability?

A. Indeed.

5 Q. And then you go on to describe your student experiences at Muckamore in the 1980s. Taking it up at paragraph 8, which will hopefully come on to the screen in a second, you say that "In the 1980s and 1990s", which is really strictly before the period of time that the Inquiry is looking at, you say that you felt well supported by managers, and you say: 10:07

10:07

"These senior nurse managers monitored patient care whilst present on the ward. Staff would expect to be asked questions regarding the management of clinical situations, such as epilepsy or de-escalation of aggressive outbursts by patients by the senior nurse managers." 10:08

And you say then:

"Managers were visible. They were familiar with all patients and knew staff by name." 10:08

Pausing there for a second, when you talk about "managers", what level of management do you mean?

A. That would be the Senior Nurse management team, what would be now an 8A, we'd use numbers. But it would still be called a Senior Nurse Manager. 10:08

6 Q. Okay.

A. They do not -- they're not based in the ward, but they

visited the ward very regularly in all of my earlier times.

7 Q. Okay. And you conclude in this paragraph by saying that:

10:08

"There was a healthy respect between management and staff. Some patients had family or friends who visited the wards regularly, although many patients had no visitors at all."

10:09

In terms of that, "a healthy respect between management and staff", I know at the outset of the paragraph you're talking about the '80s and '90s, but when did things change in your experience?

A. Yes. Well, absolutely 2012, which did correlate with the Ennis Investigation, which you may talk more about, but that was also at the same time just prior to it we had a new manager, and so the new manager wouldn't have been familiar - that was H507 - with, I felt, learning disability. But, you know, you expect when someone is appointed then that they will be able to manage with the support of the team that she would have had then as well, because it's not only -- you had -- there was at least four Senior Nurse Managers there as well and that were on site at the time, and then a full team of ward managers, Band 8 or Band 7, in every ward.

10:09

10:09

10:10

8 Q. So to summarise then, this healthy respect was really your experience up until around 2012?

A. Absolutely.

9 Q. Okay. Continuing on then just with this background and sort of introductory description that you give of your early years, you talk about your various placements as a student in a number of different wards in Muckamore. You talk about the nursing courses that you did, your experiences in Fingrove and Moylena, among others, including also Rathmore. Taking it up at 15, if I can take you to paragraph 15 on page 5. At the start of that paragraph, again this is talking about your time as a student, which would have been in the 1980s. Can you see it okay? 10:10 10:11

A. Yes, just a wee bit closer, sorry. I'm reading glasses. That's better now.

10 Q. As long as you can see it, that's the important thing.

A. Yeah. 10:11

11 Q. Now, I know that your student journey, from what you've told us, would have been in the 1980s, would that be right?

A. Yes, '86.

CHAIRPERSON: Hold on one second, let's just get the screen sorted out. So the screen is just being moved closer to the witness. Right. Can you see that a bit better? 10:11

MR. MCEVOY: Is that better ?

A. Yes. Perfect. 10:11

12 Q. Okay. So I was just asking you about your student journey in the 1980s.

A. Yes.

13 Q. And you said:

"One thing I had observed on my student journey was that other hospitals had clerical and secretarial support, however, the nurses at Muckamore Abbey seemed to do all clerical duties."

10:12

A. Yes.

14 Q. How long did that persist for?

A. I would say it was after 2000, it was about 2012 where we got like a support worker who supported the Ward Manager, so if I may ask her to help with some admin and different things that had to be prepared. But now in that time that was the very beginning of that, in around 2012, maybe '11, I would say '11, and these staff you would only have maybe half a day a week, that was it. So I had to share that lady with -- it was generally female -- with another Ward Sister on site on that day. So she'd work with me for a few hours and then go over and that was it.

10:12

10:12

15 Q. For that week?

A. That was it for that week.

10:13

16 Q. Was she based on the ward then before that time?

A. She was based in the ward. And then she went to the other ward when she was with them. Now we did have an administration building. It was -- they did have admin staff. So say I wanted a large document photocopied or something, that would be sent to them. So there were other -- but they were very clear in their duties. So, you know, you might go and say 'Oh, well really', you know, but usually that would be accommodated. But the

10:13

duties on the ward, it was very poor, the assistance that you would have got. So you were doing everything. And your nurses were doing everything. And I knew it was different because when I went to the Ulster, even as a student in '86/'87, there was somebody counting 10:13
patient's money, you know. Maybe nurses were used as well, but that admin person did that, they had very clear responsibilities, and that was not in the Trust then, that would have been -- would it be, I'm not sure, it would have been North and West Belfast, you 10:14
see, at that time, but I would have been training in there too. So that's a general hospital. So, it was a very much we knew we were doing everything on our own, and I mean counting patient's monies a few times a day with another person, and following policy that one at 10:14
least had to be a trained nurse. So, when you don't have the staff, this is very tight, you know. You're doing it at least three times a day; when the night staff come in, whenever you're handing over your day shift, and at lunch say perhaps our duties used to 10:14
finish at 1:00 o'clock, in around 1:00 o'clock, so you'd be handing over to that person, so you were counting money a lot. You were spending patient's money, hopefully they were spending themselves with the nurse, but you then had to get receipts, in Antrim, 10:15
whoever spent that money, and that may not have been the Ward Sister, you couldn't do all of it. So you then had to ensure these receipts were correct, you had to have receipts for everything. In those days also we

had a cash office that was very good at explaining things to staff, keeping people right, there still is a cash office, but these were people that worked on the site, you know, that administration building was full of resources for nurses. So whether it was even nurse's salaries, their pension, you know, but monies, accounts, medical records, it was full of people.

CHAIRPERSON: Just pause for a second. Apart from cash and patient's money, what else did the clerical staff assist you with up until 2012? 10:15 10:16

A. Well the nurses were doing everything.

CHAIRPERSON: Sorry, I'm trying to understand, at other hospitals you'd had clerical staff. You get to MAH, were there clerical staff that assisted you at the beginning and then that changed in 2012, or did you never have clerical staff? 10:16

A. We never had clerical staff until about 2011.

CHAIRPERSON: Right.

A. And then we had a ward support person who did this half day, and I think that increased to a day, a full day at least, and that was very valuable because you've all sorts of meetings, and they were extremely valuable people. Before that the nurses had been -- we were recording all the leave, this is annual leave, whereas all that used to be done by your Senior Nurse Manager, but now these jobs were coming to the ward and there was no-one really there do all of that, because that Ward Sister is meant to be out monitoring care every day and, so, you're doing a mix of this now. 10:16 10:17

Now then, in 2016, I'm jumping to there because that's where we got actual clerical assistance on the ward. They were what the ward manager wanted. So say I wanted someone to record training, I was doing it myself, with the result that I allocated this to nurses. So everybody's training, this was done by staff. Before nurse managers did that, they knew what training the staff had, you know, they knew what leave they had. They sorted those thing out. So when those jobs were delegated to the wards, at that stage for a long time there was nobody to help with that person. There was no Band 6s where I was in 2012. So the nurses were archiving books, they were -- that was a big thing, archiving books, I've been doing that myself from when I was a student, going into a store of a mess and trying to get that sorted out when you had a quiet period. 10:17 10:18 10:18

17 Q. MR. MCEVOY: Pausing there then, can you tell us what it was that, having had no support person prior to 2011 or 2012, brought around or brought about the decision to provide a person to you? 10:18

A. I don't know the reason for that, other than we did meet very regularly every month with our nurse, the Service Manager. 10:18

18 Q. All right.

A. That meeting has went on for a long time. It did change then in more recent years to become a multidisciplinary meeting, but it did -- so you got

this ward support person in '11, and when there were listening exercises as a result of the ongoing investigation at that time, it was as late as that, I was asked 'Is there anything we can do to help?', and I said 'Please, give the wards a clerical officer'. 10:19

19 Q. Right.

A. They are now everywhere on site and it's a big improvement.

20 Q. Right. So the Inquiry can take it then that it may have been, one possibility is that it was provided in response to a request from you? 10:19

A. The admin on wards.

21 Q. Yes.

A. Was.

22 Q. Okay. Just before we leave this topic then, was that person -- and I think the answer is probably fairly obvious, but if you can just straighten it out -- was this person an admin staff as opposed to -- 10:19

A. Yes, they had admin duties and qualifications, and there are many now. 10:20

23 Q. All right.

A. It began again one between two wards for the week, and then as far as I know there is just one everywhere.

24 Q. Okay. Moving on then, you go on to tell us some more in detail about your early experiences as a fully qualified nurse, leaving student nursing and as a fully qualified nurse while at Muckamore Abbey, and then you list the various courses that you took over the course of your career, you've listed them there at paragraph 10:20

18, a long list of them, reminding us then that mandatory training had different periods when each one had to be renewed. Safeguarding, for example, having to be renewed every three years, MAPA getting renewed every year, and that was scheduled on the basis of guidance provided by the Trust. 10:20

Then you go on to talk a little bit about management of aggression, which is something we'll come to a little bit later, but you say then that you learnt the many causes and particular reasons which can lead to aggression. You talk about de-escalation and so on and the various techniques used. You talk about an encouragement then at the bottom of paragraph 20 on page 7, about five lines from the bottom, and you say: 10:21

"We were encouraged to share daily briefings with..."

- there's "hotel", but presumably that must mean hospital service staff? Is that a typo? 10:21

A. Yes, the domestics in your ward.

25 Q. Yes.

"...when they began their shift on the ward also. It is fair to say that some staff were more successful employing these techniques than others. Some staff had to learn de-escalation techniques, some were very experienced, and in others these skills occurred naturally in them, they are an art." 10:21

A. Yes. Mhm-mhm.

26 Q. Okay. You go on then to say in paragraph 21:

"De-escalation for nursing usually involved observing signs of agitation and assessing the situation. The staff member who had the best relationship with the patient would usually have been selected to try and de-escalate." 10:22

10:22

When did that practice or approach, when was it sort of decided or agreed that that was the best way to deal with these situations, in other words to assign the person with the best relationship?

A. Well, from the moment I was a student nurse learning about learning disability and in the hospital, that was -- in fact the staff who were there at that stage, most of them, I would say, it was an art. They seemed to just -- they knew the patient so well, they knew their likes, what they didn't like. So, therefore, they would then know. And when I'm saying the best one, that would be the person maybe with the best relationship with, people like different people, feel comfortable with different people, and they would be able to. And very often that could be the Nurse Assistant and not the Staff Nurse, not the nurse in charge. So you used your resources. So that was from the beginning. My training was excellent, as far as aggression. I didn't see, as the years went by, a real 10:22 10:22 10:23

improvement in dealing with aggression. I saw changes and the introduction of MAPA, it was controlling responsibility I think before that, you know, techniques to allow you to manage the patient safely, which had not been there. But I felt there were less incidents whenever in the beginning.

27 Q. Okay.

A. And we had many more patients.

28 Q. And is that, when you say there were less incidents/fewer incidents, is that pre? 10:23

A. Pre. Absolutely.

29 Q. Pre?

A. Yes.

30 Q. Pre what? Pre-MAPA?

A. Physical intervention where you're working in close with a patient. 10:23

31 Q. Right.

A. You know. A lot of the patients liked that, they liked it, and they would want -- because you would then be with them close, you know, for quite a while, and you could be sitting beside someone and, you know. 10:24

32 Q. Can you give us a date for that approximately, roughly even in terms of --

A. For MAPA?

33 Q. Yeah. Physical intervention. 10:24

A. Introduction. I think it was called care and responsibility or control and responsibility. It was something I was told at the time that police used, and it was quite rigid, but we learned it, and it was very

well taught, I suppose, and very, you know, you were exercised before you did this training in your training. You were taught by nurse managers and whoever was responsible for bringing that in. And, you know. So it was well taught. But before this, for example, nurses used to wear dresses. 10:24

34 Q. Mhm-mhm.

A. We wore a uniform. Then nurses started to wear tunics, you know, you're on the floor, and we seemed to be on the floor often. 10:25

35 Q. Mhm-mhm.

A. So I wanted to hold on to my uniform, but I could see that this was the practical clothing and that was encouraged, and that developed over the years to, you know, now that the uniform is, everywhere in general is a tunic and trousers. But I definitely feel there were, because it was only whenever there was real extreme incidences that there would have been had to have been hands on before that, and it's right to say that, you know, people wouldn't have known physical intervention techniques, but they were there, they gathered together to try and stop this, whatever it was, aggression against maybe a patient most often, that you would have been intervening. 10:25

DR. MAXWELL: Can I just clarify? So during your training, you would have been taught some physical holds to be used? 10:25

A. No. No.

DR. MAXWELL: You weren't taught any physical holds at

all?

A. No. No.

DR. MAXWELL: That was quite common in mental health hospitals, but you weren't taught it in your LD training? 10:26

A. No.

DR. MAXWELL: Okay. And then you talk in paragraph 27 about a number of restricted equipments that were used, so splints, for example, to stop people banging their arms presumably. You then go on to talk about patients 10:26 having different levels of supervision, so levels one to four I presume we're talking about, and "that that increased during my years in MAH". So, two questions really: When did you start using that structured supervision, and did that in any way relate to the use 10:26 of restricted equipment or physical holds, whatever they were called, at various different times?

A. No. I won't have a date for the beginning of supervision levels.

DR. MAXWELL: Would that have happened during your 10:27 training?

A. I'm trying to think and in the wards that I was in. So that is a time when there was about 900 patients. There was certainly -- if it was at all, it was quite rare. 10:27

DR. MAXWELL: Okay.

A. I remember one man -- now I was a Staff Nurse at that time -- who everything he, when he was walking through, walking through this room, any piece of, it could be

even a tissue, he would eat. So PICA. And he had surgery for PICA, you know. So that would have been going back to 2000. And, let me see, 2000 and maybe, maybe it was late 1998. Certainly then. But it was for someone like that, that for their health condition, 10:28
if he -- he was going to either need further surgery or lose his life. People were, they were very alarmed having to -- when they knew they were allocated to this patient. I think there might have been a two to one. So that's back then, and I don't remember... 10:28

DR. MAXWELL: Okay. Okay.

A. -- much before that.

DR. MAXWELL: And you say that this using prescribed levels of supervisions or observations increased, so we're not quite sure when, but it became more common 10:28
over your time?

A. Yes.

DR. MAXWELL: Did that increase or reduce the use of splints and physical holds or did it have no relation to it? 10:28

A. Well splints that I would have seen was to stop someone -- they maybe had created a large sore which needed nursing care, medical treatment.

DR. MAXWELL: Yes.

A. So it may have been that that was used until they 10:29
slept. But that person understood that, and that was an agreement, they talked to the doctor about that, and then we had to do what they had decided. So other splints, you know, I'm thinking for physical care. And

then the second part of that question?
DR. MAXWELL: So did the use of physical holds, which had different names at different times --
A. No, I --
DR. MAXWELL: Did that have any relation -- did it go up or down in relation to having more intense structured observational supervision or did it have no relationship? 10:29
A. No, I seen them as no, no relationship at all, you know. We would have had, you know, perhaps worried parents as well is another reason. It may not have meant that observations were commenced, but certainly after meetings it may have been that that person commences a level, and that increased. That increased. But I don't see any relationship with that. I never felt it. 10:29 10:30
DR. MAXWELL: Thank you.
36 Q. MR. MCEVOY: Just before we leave the question of the practice of the prior MAPA, the practice prior to MAPA care and responsibility, going back just to paragraph 21 before we leave it on page 7. Maybe you can just help us, help us understand or clarify, if you can, the second sentence where you say: 10:30

"The staff member who had the best relationship with the patient would usually have been selected to try to de-escalate." 10:30

How was that staff member selected? Who would have

done the selecting essentially?

A. Everybody knew. Everybody would know. So you were part of the shift today here and you would know that this lady gets on with you best. And everybody knows that. So then she may say 'Do you want me to?', or the 10:30 nurse in charge would say 'Will you go and see?'. So maybe if someone lost their earrings in their bedroom and they began immediately screaming, so people will 'Oh', you know 'this lady has lost something', we would very fast -- people would, you know, 'Is she available? 10:31 Yes. Go', and within seconds she'd be de-escalating using what she knows.

37 Q. It was a sort of a team decision as opposed to a management one? You, for example --

A. Oh, absolutely. And we would have been told even in 10:31 use of MAPA that it does not need to be the nurse in charge who leads the MAPA experience.

38 Q. All right. Okay. Moving across then to page 9, and it's paragraph 24. You say that the physical, just at the top of the paragraph: 10:31

"The physical intervention I witnessed used at Muckamore Abbey was always well recorded."

And you go on then to explain how it was in patients 10:32 notes and on separate forms forwarded to the MAPA teams and discussed at weekly multidisciplinary meetings. And then:

"Later physical intervention was recorded within Datix forms alongside the incident which had occurred."

Was it always well recorded?

A. In my experience, absolutely. That was an expectation. So as a Ward Sister, you see, a Datix comes back to you.

39 Q. Yes.

A. And you have to write at the bottom of them -- I can't remember what it is, but there's a wee square, and you have to make sure everything has been done. So I would be seeing that there is mention of what physical intervention was used, and what holds were used, and you could even see who was on an arm, an arm. So at that stage, yes, where Datix forms are used. Before that the forms would also say, but those forms I wouldn't necessarily see because I wouldn't be on duty maybe every day. So if an incident happened, then that form was sent to the MAPA instructor. So that was the expectation, everybody doing their training knew and they were taught that; you use that form, that goes to.

40 Q. And it would be your evidence then that the expectation was followed through and met --

A. Absolutely. And then you were able to see. By the time Datix came in, it was different. The incident forms -- we had before an incident form procedure and then we got Datix, which is an incident form, but also incorporated the MAPA.

41 Q. Yes.

A. I preferred the incident form.
42 Q. Why was that?
A. Because whenever -- say I was doing the duty, which I had to, of going into the nursing office, which was really -- 10:34
43 Q. If you could just slow down just a wee bit, because you're giving us lots of information and we want to make sure it's all recorded.
A. Right. So going into the Nursing Office, which is where you help the wards and ensure they have their staffing every day. So a as a Ward Sister Band 7, that was asked of me, and maybe it would have been once a month or a week, and then none for a few weeks. So when I was doing that job in the time of the, we'll say, wait until we see, I want to say a lady's name, the manager who left in 2011, ehm, which was H359, she would expect me to report to her office first thing with the incident forms and anything else untoward that I had -- you would also read the reports of everything in the wards that night and you'd be handing over to the night charge as well. So. But when you came in in the morning, she would expect whoever is doing that role, even her own Senior Nurse Managers, which used to be their role every day, to report to her every day with these incidents forms, and these incident forms were important, because she could immediately know who was hurt, patient, staff, and she could --
44 Q. And she would have that information from shift to shift?

A. Yes. And that is what I preferred. When we used, we begun to use the Datix.

45 Q. Yes.

A. What happens there, yes, they're in response --

CHAIRPERSON: Just slow down. Slow down a little bit. Yep. Go on to Datix. 10:35

A. Mmm. So when you go on to use the Datix --

46 Q. MR. McEVOY: Lots of information and we just want to make sure we don't miss anything.

A. Sorry. 10:35

47 Q. You're okay.

A. What happens there is that it was fed into a system which is like, I think it's risk and quality at the Trust.

48 Q. Mhm-mhm. 10:35

A. And I might hear nothing more about that.

49 Q. Mhm-mhm.

A. Now, that -- even regarding the staff. Say someone -- there was so many injuries to staff at Muckamore, some staff would say, 'Don't bother putting a form in'. So 10:36 nurses were told put the forms in. So these forms then, this lady here would say, 'Did anybody contact that staff? How are they? I think I'll do a follow-up call'. That was immediate. If a patient perhaps -- something happened -- say a bruise on a patient, 'Did 10:36 so and so ring the family?'. So she was really, in my opinion she got the information as it happened, it might be the next day, but like very quickly, compared to I felt we were all at a loss with Datix.

50 Q. Right. Just so we can understand then the contrast, if there is one. So with the incident forms that you describe, there was an expectation that those would be completed certainly in advance of the handover?

A. On shift. 10:37

51 Q. On shift.

A. On shift.

52 Q. When you moved over then to Datix, was there a change in terms of when it was expected that a report would be completed? 10:37

A. No. Exactly the same. Nurses stayed on, and in the last few years while I was a Ward Sister, which you're talking from '17 to '19, where I can tell you what exactly happened, people perhaps living in the north coast, that's where they lived, had done a seriously 10:37 difficult day, I think jobs that no-one could imagine managing, and then still had to stay on, and they did, they did not go off shift in my ward and forget, they would know that had to be in. That was expectation throughout. It wasn't just on my ward. But I can tell 10:38 you that somebody maybe had another two hours drive to get home. Those are the worst examples, but it happened regularly. It happened so regularly then some left.

CHAIRPERSON: Can I just ask you to go back a bit? 10:38 Sorry to interrupt, Mr. McEvoy. I'm looking at one of the answers you gave about when the forms were put in, and you said "This lady here would say did anybody contact that staff member?". Right. What level of

seniority was "that lady"? I don't need to know --

A. So she was the service lead. So that lady was H359, who would have been -- now they call it the Service Manager.

CHAIRPERSON: Okay. 10:38

A. The person on site.

CHAIRPERSON: And then you're saying but when Datix came in they didn't have that sort of immediate view of what had happened on the ward. Is that what you're saying? 10:38

A. Well I was never asked to go to -- wait until we see -- H507's room, to tell her everything that had happened the day before. So I felt as a person managing this site, when does she get to understand what is happening? 10:39

CHAIRPERSON: Right.

DR. MAXWELL: But would she not pick it up from the electronic system?

A. She may have done.

DR. MAXWELL: I mean that was the whole point of moving 10:39 Datix electronically, so that more people would have more immediate access.

A. Well, if that is the case. As a Ward Sister I would not have received calls, I would not have been asked 'Is A, B, C, D done?'. So that's how I felt. This is 10:39 a different approach. It will have its benefits, I'm sure, but I would have preferred the other.

DR. MAXWELL: So were Datix ever discussed at MDT meetings?

A. Everybody seemed to be okay with it because --

DR. MAXWELL: But would they say there have been five incidents?

A. Oh, absolutely. You talked -- so say you had 20 patients on your list, you went over each one, and that could be half an hour. Now, it was once a week you did the MDT. I wasn't there when they started their PIPA, but I understand it's a similar thing, but with differences. But the MDT was once weekly, took a long time, and many disciplines at it, and that was right up until 2018/19. Very much so. 10:40 10:40

CHAIRPERSON: And at those meetings the Datix entries would be discussed in relation to each patient?

A. Yes. Yes. The main nurse prepares the report, usually on the, now the PARIS, and even before then there was a report, even way back 2000. So that -- if the main nurse wasn't there, the nurse in charge, they had everything ready that happened in the week. So from the last time that consultant met. Now she may have been in the ward as well, or he, on different days, but for a formal meeting once a week to discuss everything that happened in a week. 10:40 10:41

CHAIRPERSON: Okay. Sorry, I'm just trying to understand one thing. Say a staff member was injured, under the old system you'd have been aware that there should have been a follow-up -- 10:41

A. Straight away.

CHAIRPERSON: "Are they all right?" When Datix came in, are you saying that that sort of contact with that

staff member wasn't being made, or you simply don't know whether it was being made or not?

A. It was being made by the nurse in charge, the Ward Sister, it would have been the expectation then. But I think all I am saying is that at a senior level they were involved, or showed they contacted the wards quickly, and at all times that I could see. Where there was a serious incident on the ward they would be alerted to it, seemed to be, to me, very quickly. I don't know how the process works if you're, you know, behind the scenes. They will explain that. 10:41 10:42

CHAIRPERSON: Okay. Thank you.

53 Q. MR. MCEVOY: Okay, A12, towards the end then of that -- can I actually just deal with paragraph 25 on page 9:

10:42

"On occasions where PSNI were called, they would usually have attended relatively quickly. The PSNI discussed the situation with the nurse in charge and attempt to talk to the patient. They would try to de-escalate the situation without physical intervention. However, if they could not de-escalate the patient's behaviour, physical interventions would be used to manage the patient." 10:43

Can you give the Inquiry some idea of how often the PSNI would have been called in, for example, a given month. 10:43

A. At what period of time?

54 Q. In the period of time that you're talking about in your

statement and your experience on the ward?

A. Whenever --

55 Q. And if there was a change, of course you can tell us about that too. Sorry.

A. As a student, you know, I never seen them. As a Staff Nurse, you seen them for open days, they were present, they were part of our fun days, working with family, friends, you know. 10:43

56 Q. Yes.

A. Giving them helicopter rides. 10:43

57 Q. Of course. But in terms of them --

A. They weren't in the wards.

58 Q. But in terms of them coming in response to a call?

A. Yes. So how long or?

59 Q. How often? 10:44

A. How often?

60 Q. How often in a given -- I used a month, but I mean if that's -- if a year is a better or if a week is a better gauge, please tell us.

A. Well, as a Staff Nurse, again, most of my time I didn't really see them. 10:44

61 Q. Yes.

A. But when I was a Ward Sister, nothing to do with me being a Ward Sister, but it was I suppose from 2000 and, wait until we see, 2006 onwards, much more frequently. And, I mean, there was the riot squad that I have described in the statement required. 10:44

62 Q. Yes. We are going to come to that. We are going to come to that.

A. On one occasion. And I'm sure that wasn't the only one. You see, I can only tell you my ward, I can't say across the site how many times.

63 Q. You've described -- you do describe, in fairness to you, you do describe one incident, and we are going to talk about it. But I'm just trying to see if you can help us understand the frequency with which the PSNI were required to come to the hospital? 10:44

A. Yes. Well it could have been -- well really I can't say the hospital, because I wouldn't know what was happening in Six Mile, you know. 10:45

64 Q. Well in your own ward. In the wards --

A. In my own ward, you know, say by the time we get up to there, if it was once a month, it wouldn't have been much more than that. 10:45

65 Q. Right.

A. My later experience it was very frequently.

66 Q. Like how frequently?

A. And night duty as well.

67 Q. Like how frequently? 10:45

A. Like two or three times a week at a guess.

68 Q. All right. And when that started to happen, what period of time are we talking about? Roughly what dates?

A. Well I'm going to say, let me see, before, it would be before even the ongoing investigation times. '16, probably a wee bit earlier than that. So it's after 2010 and following on. 10:45

69 Q. Around about 2010. And did that change in frequency,

the uptake in frequency of police visits to the hospital or calls to the hospital coincide with anything else that was going on in the hospital or in the wards in which you were engaged?

A. Just that the patients that were being admitted to Muckamore were much more volatile. I mean people weren't coming in at that time because family couldn't support them at home. People were coming in for treatment, there was aggression, there was maybe drugs, there was, you know, they were running away, unhappy in where they lived, they couldn't be kept safely. There were much more admissions through the Mental Health Order, you know. So it really rose through the roof. And so the clientele, the patients that you were working with, there was much more aggression, it was a different, you know, we weren't getting people who were admitted with Down Syndrome anymore. 10:46 10:46 10:47

70 Q. Yes.

A. Which, I mean when I began training, people were in -- could not move, completely paralysed, cerebral palsy, needed help to walk, were going on the floor in little mats with wheels. 10:47

71 Q. So there was a change in that it wasn't just people with learning disabilities?

A. Or they had additional psychiatric, mental health problems. All very complex. Anybody who came in then, there was, you could see that was the change and, you know, even having staff that had experience to work with them. 10:47

72 Q. Mhm-mhm.
A. When people came in to work at Muckamore, the nurse managers would have carefully selected that they worked in maybe physical care first of all, geriatrics. There was a massive choice of wards to work in, all different conditions, and then you could move to the more challenging areas, and then you would probably go on to admission, if you were suitable, if you had skills to work in that environment. But by the time I left, people were just working anywhere. If you needed a nurse, you got a nurse, but they may not have had that training, you know. You did you feel for the staff that were coming in because there was not -- it was not managed in that way. 10:48 10:48
73 Q. Okay. 10:48
PROFESSOR MURPHY: Can I just clarify what you're saying there? Are you saying that in the early years of your time at MAH, the hospital was acting very much as a kind of respite care and other -- a kind of general service for people with learning disabilities because there weren't any community services, but as time went on the people who came to the hospital were people with much more difficult behaviours, because by then community services was doing all the respite care and kind of ordinary stuff, but you in MAH were doing the difficult stuff. Is that what you're saying? 10:49 10:49
A. I think it was thought of that way. Because we would have, I mean frequently on a Friday night we would have a call from an approved social worker wanting to admit

a patient, and that's from 2000 onwards, or before it a wee bit, and they would -- we would know. You know, 5:00 o'clock and somebody is wanting to -- now this person would not have been someone who was needing, just someone is needing a break, you know, parents needs a break, this is someone who was running away from -- there was a need, you know, it seemed to us that, yeah, we could understand, you know. So that was happening from then on. But there was, there was a wee recorded respite, there certainly was a respite service until that ended, and I remember, you know, that service ended, that there was no respite anymore for people. So there may have been services. I wouldn't be aware of all of the services that were there, if there was enough to cope with that or not, but we didn't see it anymore. We, you know, only saw people who it was an emergency, or they needed treatment, their mental health was deteriorating drastically.

10:50

10:50

10:50

DR. MAXWELL: When did respite service at MAH end roughly?

10:50

A. Well, the patient that I'm thinking about that had the PICA and was on those levels, he would have had respite. So that would have been in '98 or so, 2000. I don't really remember it much later than that.

DR. MAXWELL: So some time around 2000, a few years either side.

10:51

A. That's a total guess. Sorry I can't be more precise. There was also a children's unit, and it possibly might have lasted there longer, respite, because Iveagh still

had not been created in Belfast, and I think some happened there.

DR. MAXWELL: So when there was a change in the type of patient you were seeing, was there any attempt to upskill the staff? Because you had trained for one type of patient and you're getting a different sort of patient now, were you given additional training for people with mental health disorders? 10:51

A. No, we weren't, but I think the physical intervention was to help staff safely manage patients and attempt to do that. But there would have been, I suppose, I mean there was a forensic -- there was things offered to particular people if they wanted to do it, but as far as mandatory, no, I don't think so. 10:52

74 Q. MR. MCEVOY: If I can take you forward then to page 10 to paragraph 27. Dr. Maxwell asked you about restrictive equipment dealt with in the first couple of sentences, but you then go on to say that: 10:52

"For a few patients in Muckamore who would remove their clothes, I recall all-in-one suits being provided and worn during the day-time, but in later years staff were allocated to redress patients to help them keep their clothes on. These types of practices were discussed and agreed at multidisciplinary meetings throughout my time at the hospital, which required permissions granted by a consultant for a patient to use them." 10:52 10:53

The Inquiry heard quite a bit of evidence during the

patient experience side of the evidence about patients who would lose their clothes, and clothes being lost, personal clothing being bought by family members and then lost in the hospital. And, indeed, at least one family member described discovering their relative/patient in a onesie in the hospital, it was described as a onesie, and this was a source of considerable distress. Were you aware as time went on of issues around the control of patients' clothing and maybe a loss of control of that aspect of... 10:53 10:54

A. You mean.

75 Q. ...of care?

A. You mean of clothing they owned being missing?

76 Q. Yes. Yes.

A. Absolutely. So whenever you admitted a patient you recorded everything that they came in with. If you had to buy clothes for that patient during that period of their stay, the nurses were expected to record everything as well. And then there was a book, so that was like an admission book, you know, and everything came in that way. Everything. So it could have been a hair grip, pink. It could have been jewellery, which was -- I've never seen jewellery come in, but I've seen costume jewellery, yellow coloured. We were taught what to describe, how to describe that. So everything was accounted for and was expected to be going out with that person, unless very often these patients at that stage were in for years. You're not going to have the same clothing. I don't have it. So the nurses were 10:54 10:54 10:54

expected -- so say if you're going to throw out a coat, up know, to record that. There was a book called a "Condemns Book", and that was expected to be on that. I remember ringing -- I remember -- sorry, removing "ringing" -- I remember recording clothing that was not able to be used, and the practice that would have been expected was to, whenever that person's family came the next day, to give them, present them with the five or six items, and then they could take them home. They may have bought them a leather jacket, but maybe a leather jacket was completely ruined by wearing and needed -- so that would have been expected practice right up until I left. The only thing is, things changed like records. So where you would have kept that in a care plan and you'd rip out the page and put it into the care plan of the list of clothes, now you've got PARIS. 10:55 10:55 10:56

77 Q. Mhm-mhm.

A. And I don't think there was direction where to put that stuff. So, therefore, you had to have managers that knew to say 'keep up that condemns book, keep up that admission book and go and put those in along with the file because you may need that'. I can remember a family member coming to me because their son's coat, which was only bought a week before was missing and, you know, so you have to begin to look for this coat. You're maybe, maybe she has waited to tell you on the Sunday afternoon or something. 10:56 10:56

78 Q. Yes.

A. Maybe she has rung during the week and explained to staff, and they may have left a note, and you're coming in two days later. So there would certainly have been attempts to look for this coat. Thankfully that one turned up and, believe it or not, this lady and her husband were separated, and the coat was with the father of the patient. But that took some time. But I was glad she came back to me and told me that. But, things like that. And then that's a whole -- and would I tell the Nurse Manager because he or she is over my unit, and you're expected to be liaising with your Nurse Manager, even, you know, right up until -- I would say in the last few years that isn't the case, but it should be. The place is just in disarray. 10:57 10:57

79 Q. So if the Inquiry is to understand your evidence about that correctly then, the loss of control, or issues with retention and care of patient's property/clothing was down to PARIS, is that correct? 10:57

A. Oh, no.

80 Q. If I've taken you up the wrong way, then... 10:58

A. Well I suppose I don't know what the family are saying. I haven't been reading these things, or maybe not privy to them, but I have the experience of standing there whenever someone has come --

81 Q. Exactly. If a family member had an issue and would come and say to you or one of your staff, 'I bought my son or daughter a new top', or 'I bought them new pyjamas', or whatever it might have been, and 'they're lost, what's happened to them?'. 10:58

A. Yes. I wouldn't be blaming that on PARIS.
82 Q. Right.
A. I'd be blaming that on ward management.
83 Q. Right.
A. The nurses are expected to make sure there's lists of clothing coming in and going out. And also along the way, say someone is in for a few years, you know, to be liaising with family as to where these items are. 10:58
84 Q. So ward management.
DR. MAXWELL: Can I just ask? Did I understand you to say that this system worked for quite well for most of your time that you could usually track the item? 10:58
A. Yes.
DR. MAXWELL: Sometimes if the patient had been in for a long time and the item had deteriorated so it wasn't useable anymore, and you would write that in the condemned book. 10:59
A. Yes. Yes.
DR. MAXWELL: Sometimes because families weren't always living together, one member of the family had taken it, and you gave an example of a coat. 10:59
A. Mmm.
DR. MAXWELL: But then you said, notwithstanding the move on to PARIS, in the last few years that system didn't work as well. When did that system start to break down? When do you mean "by the last few years"? 10:59
A. Well I just mean from this investigation that's current at Muckamore, everything is not the same. There's no staff to ensure that those things are being followed.

There's no staff that know the practices. They're coming in like flying in that day and coming to a ward to be inducted.

DR. MAXWELL: So the systems that would have allowed you to track things, because you were getting a lot of agency staff and temporary staff who didn't know the systems, the systems stopped working. 10:59

A. Yes. Or no staff before that, yes.

DR. MAXWELL: So are we talking 2015? Are we talking 2017? 11:00

A. Well, I begun to feel when I moved into Cranfield 2, well into the ward.

DR. MAXWELL: Yeah. Yeah.

A. That these were new nurses.

DR. MAXWELL: Right. 11:00

A. These nurses are very professional.

DR. MAXWELL: Yeah.

A. But they're very new. And who has been teaching them all of this? So there was a great pressure. We were aware, working in the core hospital now, that we had very new staff and did they know those? Were they getting that? And, yes, it was in their induction what do you when you admit a patient, they had more than ever we had, but often it's the nurse who has worked there for years, can you remember what they're telling you, follow everything, you're watching what they're doing, and that was the best learning I thought. So when you have many, many new -- and there seemed to be a decision taken to put the newer staff into the core 11:00 11:01

hospital. I was working in resettlement up until 2016, July, 4th July, and I noticed from the moment I went to work in the core hospital that things were different there. The nurses were younger and they would have been better qualified than me, as far as qualifications on paper, but they were inexperienced. Definitely. And that would apply to nearly every ward, apart from maybe Six Mile would have been a forensic unit where people may have then been there longer doing degrees for forensic nursing, but the nurses in resettlement tended to be, if I can say, those that were there longer, and they really had those practices down to a T, you know, all of the admission, and they spent their time when they begun to move into, if they did, the core hospital teaching, teaching. Even in resettlement I was teaching the use of computers, you know, these were -- I was working with many enrolled nurses that did not -- they didn't really even -- they wanted to be with the patients. That was it, you know. So --

11:01 11:02 11:02 11:02

CHAIRPERSON: Sorry, just stop for a second because we were on the issue of clothing and we seem to have diverted.

A. Mmm.

CHAIRPERSON: Are you saying that the problems that the Inquiry has heard about and have been relayed to you by Mr. McEvoy, really started in 2016/17, as far as you were aware? Because we heard from relatives who said that the patient's clothing would not be their own when they turned up, or a new pair of trainers would just

11:03

have disappeared, or patients would be wearing each other's clothes, and we heard that repeatedly. So I just want to know are you saying that all started from 2017, or do you recognise that, first of all, as being a problem? 11:03

A. No.

CHAIRPERSON: Right.

A. No, they would have been wearing their own clothes.

CHAIRPERSON: Right.

A. Certainly that was not a feature. 11:03

CHAIRPERSON: So, so far as a change in 2017 that you mentioned, you said when the investigation started, because staff were changing, did problems arise then?

A. Ehm, probably that's what I'm telling you about, that incident with the lady and the coat, because I could remember -- 11:04

CHAIRPERSON: Yes. Well that's one incident. I understand that. But what about generally?

A. Oh, no, not really, because in the core hospital wards they had each -- in the core hospital, this is two wards, two wards, and two wards. So it was three areas with three laundries. It's no longer going to a central laundry, which would have probably a higher risk of being lost there. Some of these clothes were completely soiled, completely soiled, unimaginably what people had to work with sometimes, and it would much depend on what that nurse did with that clothing at this stage, when it was personal clothing. I could talk to you about clothing for an hour. 11:04 11:04

CHAIRPERSON: Well don't.

A. But it's very interesting, because in the beginning the patient's clothing wasn't their own, it was what was provided by I suppose government to the hospital and the money. I'll not go on. But it was -- they did wear brown jumpers, blue jumpers, green jumpers. Nurses brought that forward at Muckamore Abbey so that they started buying their own clothes. You know these clothes were funded. Now, if family brought clothes in, that was great, but it also would have the potential that it could get lost, you know. So certainly a thing if you bring something in that's dirtied every day. 11:05

CHAIRPERSON: Sure. But as a general problem of the type that I've described, you don't really recognise it? 11:05

A. No, but I would know that every now and again somebody might ask me 'Oh' -- and maybe they didn't always tell you -- but I know of the times when they did because it would come straight to me, you know, and it was left for me to, right, start to think where this could be and how this happened. 11:05

CHAIRPERSON: Yes. Okay. Thank you. Sorry, Mr. McEvoy.

85 Q. MR. MCEVOY: Chair. Moving on to paragraph, just moving on to a slightly different issue now, looking at paragraph 32, which starts at the bottom of page 11, this is around the issue of locked doors, which you describe as another form of restrictive practice, and 11:06

in this paragraph then you describe your experiences on the last ward of which you worked as a Sister, Cranfield 2, an open ward, which meant that the doors were open most of the day until agreed times and locked most of the tight. You remember having to record the times the doors were open and communicate that to the nursing office. And then:

"In the wards that were locked, I do not remember recording the details of the times but I do remember understanding the practice was for patient safety. In any area where the doors were locked, if a visitor or staff without a key/pass wanted access, this was not a problem as the nurse in charge would provide access and an escort if necessary. I reassured patients' families they could see their loved one at any time they wanted, day or night."

Now, again, during the course of the patient experience evidence, we heard a lot of evidence from family members who complained about not being able to see their family members' rooms and only being allowed into the visitor room. Now, based on your experience, do you recognise that as having been a problem?

A. No, because it was not a feature of any ward I managed.

86 Q. Any you worked on. All right.

CHAIRPERSON: We need a break at some point, so once you finish this topic we'll...

MR. MCEVOY: Yes. Do you know whether it was an issue

on other wards?

A. Ehm, what I can say.

87 Q. Or I know you can only talk about your own experience, but if you're aware of what was going on in other wards, by all means tell us? 11:07

A. Well, so, you had resettlement wards, which are very different in design and topography.

88 Q. Yes.

A. When you went into the new wards that were chosen to be the core hospital, you walked directly into a dining 11:08 room for patients.

89 Q. Yes. Yes.

A. And to the left -- they're all the same, these six wards. There is a quiet area where someone is going because maybe they're upset and they want space. 11:08

90 Q. Mhm-mhm.

A. Then the next was a glass room where patients used as a living area. Then, funnily, the staff base was in the middle of the ward. So for a family member to speak to the Ward Sister, or anyone, they have to walk through 11:08 that. Now, not at all times would that be appropriate. And I have to say, when I moved into the core hospital into the ward I was in, it was an open ward, so it meant patients were going everywhere. Families were coming right in, right up to -- there was no -- and I 11:09 was happy enough with it because of the patient group that we had, but every ward wasn't like that.

91 Q. Yes.

A. Some patients didn't, weren't going down the town on

their own.

92 Q. Yes.

A. Or they may have run away, they may have just said 'I'm going' and they may not have not -- they maybe were detained, you know. So mine was a different ward there. But what I'm trying to say, I suppose, if there was an issue of dignity, even for eating, you know, the patients we had, had difficulties even eating, you know, maybe taking off another, a nurse would be standing there expected to be there of patients who were known to do that. Somebody may just pull their clothes down when they're brought up to the table. 11:09 11:09

93 Q. Yeah.

A. So it is not always appropriate for anyone, visitor in particular. 11:10

94 Q. Yes.

A. Even family, because that's someone else's child at the next table, just to walk in. If there was MAPA certainly, nurses may have thought that person can get hurt. Those are genuine every day understandings of a nurse. 11:10

95 Q. So your evidence essentially would be then that, yes, it wasn't a problem on Cranfield 2?

A. No, it wasn't there.

96 Q. And you reassured patient families they could see their loved ones, but subject to those sorts of concerns that you've described? 11:10

A. Yes. And whenever they moved the patients from ICU into -- or from one ward into another during the

investigation, then the door was locked, because they were patients who were used to that, but put in. And the patients that were already there in the ward that I was there were not happy.

97 Q. Yes, of course. 11:11

A. It was all about freedoms and liberty, and all those things came up then.

CHAIRPERSON: All right. Okay, we're going to take a break. It is really important, please, that you do not speak to your supporters about your evidence. Will you 11:11 give me your assurance that you won't, please?

A. Yes, indeed.

CHAIRPERSON: Thank you. Okay. Do not speak about your evidence, either the evidence you've just given or the evidence that is to come, and we'll see you back in 11:11 a quarter of an hour.

A. All right. Thank you now.

CHAIRPERSON: Thank you very much indeed.

SHORT ADJOURNMENT 11:11

THE HEARING RESUMED AFTER A SHORT ADJOURNMENT

CHAIRPERSON: Thank you. Welcome back. Thank you.

98 Q. MR. MCEVOY: If we just touch then, A12, on the next 11:32 paragraph, which is on page 12, paragraph 33. Have you got it okay? One discrete point out arising out of what you say here on the issue of seclusion, you say:

"Seclusion, like physical intervention, was from the outset considered as a last resort. I saw seclusion being used during my time as a student until recent times. It's use was always discouraged, but when it was required it was often because of continue violence against others which could not be de-escalated." 11:33

And then you say:

"Its use was closely monitored, recorded and supervised whilst it was ongoing." 11:33

Can you tell us whose duty it was to record seclusion when it occurred?

A. It would be -- well it was a trained nurse usually. That changed over the years. The policies changed over the years, obviously. So a trained nurse usually, probably in the last policy, and also it changed when Covid occurred. So it was reviewed regularly, and I remember that beginning when 507, it came in around that year, 2012, the first policy review I remember, and there may be four or five since, different policies, you know. So. But it would have been the trained nurse, and the policy is in every ward, and then it became -- it's on the computer, but the Trust Intranet, and people would have been, if they were unfamiliar with it, it's there in every ward, and they would have been aware of their duties, you know, they should have been. Anybody who was allocated to monitor 11:33 11:33 11:34

seclusion this is.

99 Q. Yeah. But to summarise, the person responsible for recording seclusion when it occurred was a trained nurse?

A. Yes. Unless the policy at that time... 11:34

100 Q. Said something different?

A. -- would have been a nurse.

101 Q. A nurse.

A. And it could have been a health care worker. But...

102 Q. Well were you aware, and you mentioned 507 there, but were you aware of a change in policy over time? 11:34

A. Oh, definitely. Those policies are all very different.

103 Q. Right.

A. The seclusion policy, and need to be read very carefully, because -- I'm trying to think of examples of the differences. It could have been 15 minute in the beginning, many years ago, where you watched the patient every 15 minutes, until then it is continuous, you know, and you then recorded every 15 minutes, but you had to be there as well. 11:35 11:35

104 Q. Mhm-mhm.

A. You know. So the changes definitely to policy over the years were there. But the nurse in charge I mean had to -- they spoke to the medical consultant to authorise seclusion. 11:35

105 Q. Yes.

A. And if it had to occur, immediate, then they had to ring them as soon as they got to that phone, you know, around to the office to discuss the seclusion of

someone. Also you had to let the Nurse Manager know immediately as well, and family.

106 Q. In paragraph 34, you say:

"The staff support systems at Muckamore Abbey were really effective as long as I can remember, with senior nursing personnel on site covering 24 hours a day." 11:36

And you say then:

"The senior nurses also had access to an experienced senior nurse on-call. There were also medics on-call every night, including a specialist registrar or consultant. The senior staff were there to discuss management of patient behaviour at any stage or other aspects of ward management. They provided expertise and direction. There were all heads of departments available during the day. For example, transport manager, the estate's manager and the hotel services manager." 11:36

You say then:

"This changed dramatically, however, in the last number of years, with a lack of senior staff with relevant experience for staff to reach out to for guidance or support, which resulted in many staff leaving as they would explain they no longer felt safe." 11:37

Can you give us an approximate date on the dramatic change that you describe?

A. Again, it would have been when the current investigation began, and that's simply because managers changed and they weren't, I felt, as experienced. Staff felt it. In my practice I used to be really confident to say to a new staff member, and that could have been a health care worker or trained personnel, particularly the trained person who was going to be nurse in charge, 'Do not worry, there is support on site', and I would have described how there's a nursing office, you know, that there was, and that was removed during this investigation, which I thought was unusual. But there was a nursing office 24 hours a day. Someone was -- it could have been a mobile phone -- but night and day. So anything that a nurse, say it was somebody who had to be secluded and you were a new nurse, there wasn't, you know, trained staff on, you could ring that person about any of those management issues. 11:37 11:37 11:38 11:38

107 Q. Yeah.

A. That changed, but that was only really in around the time of the current investigation. Up until that time there was support. And I felt it, because staff were walking away, they were leaving, and they didn't feel supported was their number one reason. 11:38

108 Q. Okay. You then talk about - I think in the following paragraphs you're describing some more of your earlier experiences which really predate the Inquiry's Terms of Reference throughout the 1990s. But if I could take it

up at paragraph 42 on page 15, at the bottom of page 15. This paragraph in which you say that from when you started in 1985 up until 2012:

"...Muckamore Abbey was a well-known teaching hospital. Almost every nurse I met hoped for a job there when they qualified." 11:39

And then you talk about seeing large visiting groups from other countries, including Romania, being shown around the site. That your learning was being shared far afield. You witnessed numerous visits to the site by large groups of executive personnel who walked through the most challenging of wards, talking to patients and staff. Often commented to the staff giving appreciation for their dedication. 11:39 11:39

You say then overleaf on page 16, at top of the page:

"This was mostly in the time of the Eastern Board and the North and West Belfast Trust, which I believe was from when I started in 1985 until the Belfast Trust took over the running of Muckamore Abbey some time in the middle of the 2000s. There were few visits from Belfast Trust executives on the wards in more recent years." 11:39 11:40

How many, roughly, in your time since the Belfast Trust took over, or can you give us an idea?

A. Well I don't remember meeting any. So there may have been individuals who came up and may have come over to the ward, but not as a group like that, that I would have understood where executives who were behind the scenes, you know. Whereas, to be honest, it was really quite often, it may have happened every other month before, it felt like that. You were -- maybe even the time as a student, as a Staff Nurse, I would be in a day space with patients and somebody might say 'Oh, we're expecting visitors'. 11:40 11:41

109 Q. Yes.

A. And another time there may be no advice that you're getting a visit and people walked on in, into the area, and they would move around the whole unit. They would walk right through the bedrooms, the dorms, they would ask questions of nurses who were around. That -- to be fair, I don't remember any visit like that, but certainly there may be some individuals, but it's sporadic, and it may not have been when I was on to even remember. 11:41 11:41

110 Q. Mhm-mhm. When you talk then in the remainder of that paragraph about how the importance of research and its encouragement, indeed among the nursing staff, and you mention one of your own studies. You then say on down in paragraph 43: 11:41

"Patients were included and made to feel important. Staff in all departments would often say 'If it was not for the patients I would not be here'."

And you say that was said by a joiner.

A. Mhm-mhm.

111 Q. "...recognising that the patient was at the centre of focus at Muckamore." 11:42

And you describe the sports programme which was in place up until the early 2000s, and you talk about some of the sports that were undertaken. You talk about how the hospital had its own Horticulture Department through day care in the '80s, '90s and the 2000s. The day care facility providing occupational therapies, including the pool. You talk about how there was a Patient Council Group within day care called "Tell It Like It Is", and in summary you say then that: 11:42 11:42

"Muckamore site was buzzing with creativity and a friendly atmosphere, many staff who could have moved on to develop their own career chose to stay there." 11:42

Was that always the case in your experience?

A. Majority.

112 Q. Yeah.

A. Indeed. You know even myself. I got a job working in a school, as a school nurse, and when I thought about it, when I was leaving, I didn't know -- because there's a good team atmosphere, and support, and in those times it was strong. 11:42

113 Q. So you were offered a job working as a school nurse which would have meant leaving Muckamore?

A. Yes, got a job. Yeah. And I didn't take it.

114 Q. And you didn't take it.

A. Out in the community. 11:43

115 Q. When was that, do you remember?

A. Oh, ehm, that was in my early Staff Nurse days.

116 Q. Right.

A. So, '90s.

117 Q. In the '90s. All right. Can I then -- you then talk of course in the succeeding paragraphs then about your various job roles and moves and how you moved through the ranks, and then what that meant for working in the various wards. And then you say that, I think just taking it up just to close that point, that in 2004 -- this is paragraph 49 on page 18 -- that you took up a permanent Band 7 post as a Ward Sister in Moylena in which you had been a student nurse, and that was -- was that your first big promotion? 11:43 11:43

A. Yes. 11:44

118 Q. And you say then it:

"...made you feel an overwhelming sense of privilege and you felt trusted to safeguard the patients under your care from every aspect of their care and I took this responsibility very seriously." 11:44

Then you went on to complete a leadership and management course offered by the Belfast Trust in 2006

at The Beeches. Was that true of other colleagues as well? Would you say that they would have had the same experience as you, the same sentiments as well?

A. Yes, I would indeed.

119 Q. Okay. 11:44

A. Still feel the privilege, but not trusted, no longer.

120 Q. Okay. Can I then just take you to paragraph 50 on page 19, and here you talk about your time as a Ward Sister on Fintona South Ward. Can you remember roughly when that would have been? 11:45

A. Oh, yes. Right. Wait until we see. So Fintona South Ward was actually patients from a ward called Movilla B.

121 Q. Yes.

A. And I think it was in relation to the closure of -- 11:45 initial closures of the older units.

122 Q. Yes.

A. So I had got my post in Movilla B, and that was just before Ennis, so it could have been in and around 2006, I'm going to guess, and then they decided, the 11:45 management team, to move the patients from Movilla B, which was adjacent to Movilla A, a locked area. Movilla B was an open ward.

123 Q. Just slow down a wee bit because we've the stenographer taking a note, so we want to make sure we get 11:46 everything.

A. And we moved in that year over to Fintona South. So it had always been female.

124 Q. So that year would have been 2006, did you say?

A. I'm going to say, yes, six or seven.

125 Q. Okay. And how long were you in Fintona South Ward for then?

A. Well, because it's the same ward as Movilla B, I'm thinking probably nearly two years or less. 11:46

126 Q. Okay.

A. Because there's Movilla B, Fintona South, and then that ward became Movilla B again.

127 Q. Yes.

A. Because they moved the patients back -- after going there, moved them back to Movilla B, but I was there throughout. 11:46

128 Q. Okay. Now in this paragraph you tell us about an incident involving a patient, and you say you recall being on duty one day when a patient lifted a brush and began to swing it round and round in a threatening manner whilst other patients were eating their dinner. Can you recall what year this would have been then? We're talking about 18-month or two year timeframe here? 11:47

A. So if it was before they moved back, I'm thinking it was 2007.

129 Q. Okay. And:

"The patient was male, really angry, very strong and threatening violence." 11:47

-- you say:

"I heard the commotion as I was nearby and went to assist whilst staff were moving other patients from the area to a place of safety whilst we talked to the upset patient in order to de-escalate the situation. The patient remained extremely angry. He was holding a floor brush and continued to threaten violence. I called the Nurse Manager H823, who attend, and I explained that the PSNI would be required. PSNI special forces arrived dressed in riot gear. They took an assessment of the patient's medical condition." 11:47 11:48

Pausing there. Did any member of the PSNI identify themselves as medically qualified or in a position to make an assessment of the medical condition of the patient? 11:48

A. They didn't, but I would already have also rung the medical team and the nurse. I maybe haven't included that.

130 Q. Okay.

A. Any incident, that's what you're expected to do. 11:48

131 Q. Okay.

A. But they were not there at that time when the police came.

132 Q. Yeah. I suppose before we go on with this incident, obviously a little bit earlier in your evidence we discussed how the frequency with which the PSNI in your experience were attending during this time in Fintona South Ward, and you've described how there was a bit of flux, or wards were being closed and there was a 11:48

mixture of patients.

A. Yeah.

133 Q. Were PSNI calls and visits a frequent occurrence at that time?

A. No. 11:49

134 Q. Okay. You then go on to describe how you had managed to isolate this patient into the inner courtyard:

"Meanwhile he was punching every window with the brush handle. There were small broken panes of glass inside 11:49 and outside. He ripped the summer seat apart and using the metal side began to smash the small glass panes with it too. I remember having to administer an intramuscular injection while the police officers held the patient. I knew the patient well, we had a good 11:49 nurse/patient relationship. I was talking to him throughout as I noticed the PSNI helicopter hovering overhead. I was grateful for the quick response. The patient was taken to the local police station and spent one night there. The patient's family were kept fully 11:49 briefed, as were the patient's consultant, Doctor H41 and the duty doctor. The patient was reviewed the next morning by the PSNI and by the multidisciplinary team. We had further meetings to put a course of action to avoid future re-occurrence." 11:50

You then say at paragraph 51:

"We were unable to manage this patient on this occasion

as he had not been taking his prescribed medication. I felt heartbroken to know that he had been kept in cells overnight. The whole situation was traumatic for him but we needed the assistance of the PSNI to manage him." 11:50

On that final point in terms of the trauma for the patient, you say, of course, and you note, that he had not been taking his prescribed medication. I suppose whose responsibility would it have been to ensure that he got his prescribed medication? 11:50

A. So the nurse in charge. Well, the person giving out the medication may not always be the nurse in charge, so the trained nurse on duty perhaps allocated, perhaps, the nurse in charge, you know. 11:51

135 Q. And you note the trauma, and I mentioned that. You said at the foot of paragraph 50 that there were further meetings to put a course of action to avoid future re-occurrence.

A. Mmm. 11:51

136 Q. What sort of -- in other words, what sort of analysis was done to review what happened on this occasion? Because presumably the idea of a patient being taken to spend the night in a police cell is not optimal.

A. That would have been treated very urgently. The next day there was a meeting I wasn't at, and I don't think it was held on the ward, and I know -- I believe the Patient Consultant 41 was involved in that, and whoever was there on duty on that morning. I think I came in 11:51

in the evening. We were doing morning and evening shifts at that stage. And then in that week also, it was fully discussed at the multidisciplinary meeting, because by that stage you would know how he was, you know, family input, anything that -- just what had happened then.

137 Q. There was a meeting in the immediate aftermath?

A. There was. I wasn't at.

138 Q. At which you weren't there. Do you know what level that meeting took place at? 11:52

A. Consultant. I would imagine it was Service Manager. They were -- that's how I explain about the incident forms and how they knew straight away. So she would have been fully informed before, and even through the later times would have been fully informed of all of those incidences, so I think I'm going to say Service Manager level, but there would have been input from the Senior Nurse Manager, she was present. So I can imagine that would be the normal form to have at that senior level, and if the Ward Sister was there perhaps. 11:53 But they had their own, it was just like the hospital management team, that I wouldn't have been at. They met monthly.

139 Q. Yeah.

A. And that would have been the consultants. So they then 11:53 were advising anything we had to do, and they would have talked to the nurse in charge and then to me, and that's how I knew it was even on.

140 Q. Now, I'm not asking you obviously to say out loud if

you know it, but do you recall the patient's name?

A. Yes.

141 Q. Okay. And would you be good enough just to write it down on a Post-It note and pass it to the Inquiry Secretary, please? 11:53

A. Mhm-mhm. Thank you. (SAME HANDED).

142 Q. Thank you. Thank you.

CHAIRPERSON: Is that somebody for whom we've got a cipher?

MR. MCEVOY: I don't think we do. It's not a name that's immediately familiar. 11:54

CHAIRPERSON: Okay.

MR. McEVOY: Moving then just to paragraph 52 then, and you describe how in 2008 you were asked by the Service Manager H359 to transfer to Ennis Ward as Ward Sister and to prepare for a period of retraction and relocation of patients in the future. And you then describe how H359 explained to you that: 11:54

"It was expected for there to be a high level of patient movement and that I would be familiar with some of the patients. At this time I had good all round experience working in a mix of physical care and/or severe challenging behaviour wards, and H359 advised me that my skills and experience would suit this post." 11:54 11:55

Did H359 sort of describe this to you as, in terms of not officially as a sort of promotion of some kind?

A. No.

143 Q. Right. And were you given any sort of an incentive -- I beg your pardon, incentive to take the role?

A. No.

144 Q. No?

A. We would have, even throughout the different posts, student staff nurse, you know, expected we could be moved anywhere at any time, and although I could have probably delayed this or wanted -- 11:55

145 Q. Could have had a discussion with her?

A. Yes. I respected her and her understanding. 11:55

146 Q. Yes.

A. Of what the plans were.

147 Q. Yes.

A. And it had been a couple of years where I was, so I had no real reason to. 11:55

148 Q. Okay. At that time what was your view about the whole concept and idea of resettlement into the community?

A. From I began in 1985, we were resettling patients.

149 Q. Yeah.

A. As a student nurse I would have been part of resettlement meetings, and they were huge then, and very well organised. So resettlement wasn't anything new to me, because every ward that I was in, there was somebody resettled from it, or the ward was retracting even from -- the hospital was retracting from then and wards were being closed over my time. 11:56 11:56

150 Q. Yes.

A. It wasn't a new thing this time.

151 Q. That was my next question. So as far as you were

concerned and from your discussions with H359 --

A. I understood they were -- it was getting smaller.

152 Q. Yes. It was just a new, simply a new stage along a process?

DR. MAXWELL: Can I ask, was the speed at which resettlement was to happen increasing? Was there more pressure at this time? 11:56

A. That was from -- I noticed that from 2012.

DR. MAXWELL: So in 2008, this wasn't part of a big drive, it was just part of a normal sort of thing? 11:57

A. No.

DR. MAXWELL: The stepwise change came in 2012?

A. Yes, felt the pressure then. So in 2008 I would have been aware that wards were continuing to close to end up with what the view that I thought it was going to be was a core hospital of six wards, and I knew that from when I started my training, that was the plan, you know, it was known then. So that was all part of that. I understood that. I understood that the hospital, you know, it was community care, even at that stage we were working towards that, we were supporting patients through those meetings and for people who had lived there for maybe a few decades, you know, it was quite frightening for them. 11:57 11:57

DR. MAXWELL: You actually talk earlier in your statement in paragraph 15 about tutors during your training in the '80s talking about resettlement schemes in Sweden. 11:57

A. Yes.

DR. MAXWELL: And you had mentioned again that you knew from the start that resettlement care in the community was the aim.

A. Yes.

DR. MAXWELL: But we've also heard from other people that a lot of staff were resistant to the idea of resettlement. 11:58

A. I didn't see that at all, because in Muckamore there was lists as long of patients that needed to come for treatment, even in the more latter days, and there was. So I never felt 'Oh, my job is in jeopardy'. And even if it had become that somebody said 'Muckamore is closing', I would have been going out with the patients. So I never felt, you know. But -- 11:58

DR. MAXWELL: But how do you think other staff felt? Because we've heard some people felt that because of the complexities, the family wouldn't be able to provide the care and actually they would get better care by being in Muckamore? You didn't feel that. 11:58

A. Oh, staff thought that? Staff felt that? Some staff. 11:58

DR. MAXWELL: Did you know other staff who felt that?

A. Yes, some staff did, because we had a patient in 2012, who is 208, who the staff said -- we felt, just felt she had been there so long, I have mentioned her already I think in my statement, and that she had been an orphan and then she came to Muckamore, it was all she knew, her behaviours had changed, mellowed, we thought, from she came to that ward in 2008. And she definitely benefitted, but it took a long time. She 11:59

had a lot of autism, confusion, aggression, you know, and then when she went -- I went to see that myself, that nursing home, and it was -- it looked -- she had lots of space I thought. But she died.

DR. MAXWELL: Yes. 12:00

A. And the nursing staff, you know, then -- at the end of the day their concerns, you know, were that she would never be here if she went out. So I would say that did exist amongst a number of staff.

DR. MAXWELL: Yes. 12:00

A. I tried, you know, like we had a lot of contact with the people who they were going to in that time, at that time, and a lot of information was shared, comprehensive risk assessments, you know, all the care plans, meetings. There were booklets provided "All 12:00 About Me", where someone would sit down so this could be read out and shared, and that's for quite a while they existed. Social worker reports. Everybody had an input. Behaviour nurse. If perhaps -- that lady herself, she dragged her leg -- you know, physio input. 12:01 Anyone connected was at those preparations for resettlement.

DR. MAXWELL: Yep.

A. And even at that time for her, you know.

DR. MAXWELL: Okay. Thank you. 12:01

153 Q. MR. MCEVOY: So A12, you then talk from paragraph 54 through to about paragraph 57, about the changes that you noticed up to and in and around 2008 when the Belfast Trust took over the running of Muckamore, and

around the same time that you transferred to Ennis, and you describe some of the facilities that were there, and we touched on some of these things a few moments ago in paragraph 43.

12:01

"There was a large recreation hall that was used to provide many activities festive times for patients and families. There was an entertainments manager who orchestrated most of this, organised annual gala days for the patients and their families, well supported by staff and the local community."

12:02

Allowed for various activities that you've listed; indoor football, badminton, weekly cinema, discos, dances, and so on.

12:02

"The hospital choir practised there and sang at religious services at the weekend. It was a great space which was well used by our people, many who just liked to have a safe space to wander about in. These areas were supervised by all staff at all times. It is almost impossible to remember how many positive activities were offered in this building over a 50 year period."

12:02

12:02

You then say it was flattened, which was a huge blow to the activities available to patients after 2008. You say that this was sad for patients and staff. It affected the entertainments manager, H608:

"...as the hub of his events and activities had disappeared, but he came into the wards, he played music and held parties four the patients in them, and the patients loved this individual because he made them feel special."

-- you say:

"They rushed to see him vying for his attentions, requesting to be the first to sing and dance and perform. I called him the "music man". He retired a few years later and there was a significant drop in activities on site." 12:03

You then describe how, in paragraph 56, how Muckamore Abbey's transport reduced services in and around 2008 also, meaning that they would only take patients to day care and for appointments. You say you don't know who made the decision but you assume it was someone higher up in the Belfast Trust. 12:03

How were those decisions communicated to you, certainly that one, for example, around transport, how would that have been communicated to you as a Ward Sister? 12:03

A. Through the monthly meeting.

154 Q. Okay.

A. Everything was discussed, shared at that Service Manager's meeting. It was very important.

155 Q. Were you given reasons -- were reasons for decisions like that explained to you?

A. There was a lot of questions asked. I can remember different people asked --

156 Q. Were you given answers? 12:04

A. Well more or less they were told that it was happening -- it was the same as a few other things -- that was what was going to happen, we would no longer have it I think.

157 Q. But no reason why? 12:04

A. Well somebody in the Trust said it had to happen and, you know...

158 Q. All right.

A. At the same time, there was an issue of where was, they tried to introduce lease of vehicles, and if you want 12:04 to --

159 Q. You go on to talk about that. Yeah, I'll let you talk -- no, no, no, please do talk about it, yes.

A. Right. So that was offered to all Ward Managers, but people could see what that was. 12:04

160 Q. Yes.

A. You know, you were basically the job -- because somebody was going to have to drive that. So people had to learn to drive that vehicle, you had to do a wee test. Our Transport Manager, go out with him in the 12:04 car, and if he was happy then you could drive the car. You had your driving licence, you know.

161 Q. That's fine. That's fine. So nursing staff were doing the job of the driving that had previously been

undertaken by transport services?

A. Yes. Yes. Nursing staff in the main enjoyed this, because they could get out for the day. They were taking the patients, the patients loved it.

162 Q. Yes. 12:05

A. So. But I took the benefit of one of those, and there was only one other ward did, and there might have been 14 wards at the time.

163 Q. Mhm-mhm.

A. So if you think two wards had that and they were -- 12:05
then it was sitting at the door and -- so you could use it. And it was well used. Ours, I can speak of. So three times during the day, staff are asked to record who went out, when they went out, how long they went out for, what their activity was, and this was really 12:05
in preparation for resettlement.

164 Q. Yeah.

A. And this is what my Nurse Manager, who would have been, let me see, H377, encouraged, he thought that was great, because during that we were teaching the 12:06
patients to go up and pay for their goods, what they wanted, we got a lot more opportunities to teach, which went along with resettlement and getting ready to get out there, and people who hadn't ever --

165 Q. Of course. 12:06

A. Like that lady I told you about, she would never have had that.

166 Q. Yes, of course. One of the other reductions you talk about then at paragraph 57 is in relation to the

pharmacy which was closed in and around 2008 and moved to the City Hospital, with the consequence that medications were no longer available on site, had to be obtained from Belfast, and the pharmacist was transferred there too.

"She had begun good work attending multidisciplinary team meetings to work with the consultants at patient reviews. The service was no longer available. It recommenced around ten years later with a part-time pharmacist assigned to Muckamore called H741."

Then you talk about how:

"...staff services, such as Human Resources, wages and salaries were closed, transferring to McKinney House on the Musgrave Hospital site."

You then describe how:

"...Maintenance Managers such as H846 attended meetings in Belfast and would have told me that we were seen and referred to as the "nursing home over the hill"."

A. Absolutely, yes.

167 Q.

"When I worked in Ennis Ward from 2008..."

-- you tell us at paragraph 58:

"...there was an activity book with, on average, three or four entries daily, involving taking turn for all patients. Staff on duty recorded activities in this book and in the patient's care plan. Beautiful grounds were an amazing sight all year round of many trees and shrubs, flowerbeds with colourful scented roses and the flowering bushes were a delight to behold."

12:07

And you talk then about how the hospital gardens were tended by the gardeners from the horticulture section of the day care and the patients who expressed a wish to join the staff in these gardens never looked so well. It was therapeutic work for patients. Something else then that was also lost in and around 2008, is that right?

12:07

12:08

A. All of those things?

168 Q. Yes.

A. The pharmacy.

169 Q. Yes, and the others.

12:08

A. Yes, one after the other. And the knowledge then. And it's different, when you walk over to pharmacy that's on site and there's the pharmacist and anyone can even ask her about the medications, including the patients themselves. Now you ring, we then had to ring up through a number that's a list on a Board, to speak to somebody who is part of a big Trust who might not have time to speak to you.

12:08

CHAIRPERSON: Can you just pause for one second.

Sorry, my transcript has stopped working. If everybody's else's is okay? Fine. I'll catch up later.

170 Q. MR. MCEVOY: Okay. In the following paragraphs then from 58 onwards, you talk about your experiences in the early part of your time on the Ennis Ward and the transfers in and out of Ennis, and you say how, at paragraph 59, that the changes were manageable and it was during this period that the patient experience excelled. 12:09

A. Mhm-mhm.

171 Q. What do you base that on, that the patient experience excelled?

A. Excelled. Because the patients were now doing things that I did when I was off duty. They could go to Belfast to see Elvis Presley, you know, act, and they could stay overnight in a hotel, maybe just for one night. But they could get their nails done -- this was an all female ward -- in a nail bar. Nurses were using their own time to attend these things. They usually got it returned to them, but I would say there were many hours, when I think of Muckamore and all that nurses did off duty, buying presents for everything that happened during the year, clothes, if a patient could not go out. So they excelled. There are also activities and pictures that we have on site, they're on CD form, but each patient was given them as a little album, they should have that in wherever they are now, and that shows what kinds of activities. And I did see

it in the Leadership and Governance Review where there was comments noted, I think perhaps by RQIA, that they weren't seen at that time and, really, this ward was a way out front. Certainly would depend on the time that they came, as far as when I was writing, raising concerns about staffing in 2012, you know, the activities were beginning to get very restricted then. But even the last group that moved in of those patients there, moved in, in 2011, the end of, were benefitting from those trips out. 12:11

172 Q. Yep.

A. They have ironing, doing skills, daily living skills that they would not have got in other wards, because Ennis was an open ward, it wasn't a locked area, and we were able to use our own time and whatever time we had to do things. People were allocated activities. There was groups responsible for ensuring there were activities. So it was really quite a gunk to read that and a real insult. 12:11

173 Q. Yes. Well just before we move on to that. I mean what you've done helpfully is actually summarised what you tell the Inquiry in your statement about all of the things that were provided and the experiences from your perspective that were available to patients on Ennis. I suppose if we look at paragraph 71, indeed, what you say is that -- this is on page 26, half way down, two thirds of the way down page 26, it is paragraph 7: 12:11 12:12

"With a high level of activities and community exposure

as a team on Ennis Ward, we watched patients' behaviours become less challenging and actually de-escalate as they played and learned to relax with staff, enjoyed being presented well and being praised for their appearance. The patients enjoyed the activities that they were involved in. The staff kept a record of these activities which recorded when patients went out, where and with whom and what they enjoyed to do. I delegated particular staff to co-ordinate activities but all staff participated when on duty." 12:12 12:13

So I suppose what we can take from that, and you can correct me if I'm wrong about this, but there's a correlation, or a correspondence between high level of activities and exposure to life in the community with a better -- improved patient behaviours and experience essentially? 12:13

A. Absolutely, if we had longer, but we didn't.

174 Q. Okay. Can we move forward? I think over the following paragraphs you sort of talk about some particular instances. Indeed, you talk about that Patient P20 -- at page 27 -- this is Patient P208. I don't intend to open that at length, but you've given us an idea certainly of who she was in paragraph 73, and her background. But if I can move forward then through the next number of paragraphs, just to pick up on what is said at paragraph 80 on page 29, and you begin the paragraph by noting that: 12:13 12:13

"In October 2011, female patients from the core hospital, namely Killead and Donegore, came to Ennis Ward, which changed the dynamic of the ward."

Were you consulted about the introduction of patients from those wards?

A. From the beginning, whenever I was asked to go, I knew that that was changes that may incorporate patients from the core hospital under the -- as it was opening. 12:14
So it opened, I'm not sure, 2006/2008. So that was opening, and as Ennis was beginning to take some patients from an older ward which would close. So, no, I wasn't involved in that, but I was aware that there would be a lot of movement. 12:15

175 Q. You had an understanding essentially?

A. I worked in that, you know, in different wards, I had closed a number of wards, completely decommissioned them, so I had experience in that. It wasn't -- I didn't -- I did know that the staff team, it might be 12:15
new to some of them, the more challenging patients that came at the last, so before the end of '11, that they might need support, and there were behaviours support, despite what one report presents that there was no behaviour management. You could ring somebody and say 12:15
'I think so and so, could you come and speak to them about how to manage this particular thing?'.

176 Q. Yeah.

A. Or patient. And that was done without a referral, a

formal referral. So they wouldn't always have that. But if there were -- like there was one patient came who was removing her clothes all day, and I said -- and this was when she was moved over, she did that in the last ward too.

177 Q. Which ward did she come from?

A. She came from Fairview.

178 Q. So not from Killead or Donegore?

A. No, it was a different ability of patients --

179 Q. I just want to focus then on Killead and Donegore, if you don't mind. You've said you don't recall any consultation with you about that decision? 12:16

A. No.

180 Q. No. And, therefore, we can take it that you weren't given a reason as to why Killead and Donegore were coming into Ennis, those patients? 12:16

A. No, other than that this core hospital had to work.

181 Q. Yes.

A. And they would have to make moves as to what happened there. 12:16

182 Q. Yes.

A. But, no.

183 Q. Okay. Well you say that this changed the dynamic of the ward. Can you tell us what you mean by that?

A. Well, before then Ennis had been patients that, I suppose, were less able. There was kind of two areas; the front area where patients maybe had some use -- they had separate rooms, they had their own room. Then the area in the lower end of the ward were less able, 12:16

you know, because the front area was if you had went outside, because it was an open ward, there's traffic, there's transport, everything, so those patients who were more independent would have been more that area. So whenever -- so you're still talking about the Killead/Donegore. So whenever they came, their behaviours were much more challenging. Extremely! And the nurses really did their best. Now in the beginning that was very manageable, it was very manageable, and I watched that, they were getting their activities, all the capabilities, all the different types of patients we had were getting activities appropriate to their ability and seemed to be getting enjoyment from that. We had patient forums there, and whether the patient could speak or not, they were attending them. So, you know. And even when someone doesn't speak, you know, we can be advocates for the patient and we would know if they were happy or not. Now, it was simply whenever we ran out of bodies. We needed a certain amount to cover that type of challenging behaviour. The nurses were all expected to manage, and knew how to manage that behaviour, but they could not manage when they were given resources of four, when they needed at least seven. And you can count the seven simply if you're there and you understand their needs too in this area. One is doing the drugs, doing the calls, things like that. Two in this area, two in this area. Seven. So it was the bottom line.

12:17 12:18 12:18 12:18 12:19

184 Q. Yep.

A. And you could attend activities with all groups of patients that came to Ennis for, I would say, it was a good four months/five months, and then I started to see summer approaches, we used to have things in Muckamore like summer workers.

185 Q. Yeah.

A. No longer. The reasons for that, I think age wise and, you know, as well we now have forensic patients, forensic ward on site. So there was -- for whatever reason there was no staff, and the staff team in Ennis worked over and above banking shifts, there wasn't agency then that was coming in. I don't know. But there was -- we were asking for it from I would say about May.

186 Q. Yep.

A. I really seen what I felt tight.

187 Q. And I want to give you the opportunity then to tell us about that, because starting in May, and I think at paragraph 85 on page 31 -- well, towards the end of paragraph 84 you say:

"By May 2012 the staff on Ennis Ward were literally run off their feet."

And then at 85 you talk about an e-mail sent on 25th May to -- is that your manager, H377? Is that your immediate manager, is it?

A. Yes.

188 Q. Okay. You then sent another e-mail on the 1st June,

which you described at paragraph 86 to same individual?

A. Yes.

189 Q. On the 10th June to the same individual?

A. Yes.

190 Q. On the 22nd June to the same individual. On the 12th July, coming to the bottom of the page, to the same individual. And then at paragraph 90 on page 32, it's 4th September 2012, that manager H377 sent you an e-mail suggesting that only one member of staff was enough on Ennis Ward -- night staff, I beg your pardon, was enough on Ennis Ward instead of two: 12:20 12:21

"I responded by e-mail to him to advise that this was not possible given the needs of the patients and the new patient mix. H377 did not push this any further." 12:21

Then you say at 92 that you didn't receive a written response:

"I often didn't receive a written response to my emails raising concerns with H377. On a few occasions he responded by visiting the ward to discuss my concerns verbally. I have copies of these emails and can provide same to the Inquiry if requested to do so." 12:21

Now, thinking back to that round of emails over a period of time, you've described the issues that you were setting out about staffing, do you think there might have been a way that you could have raised the

staffing shortages concerns in a way that would have been listened to?

A. Well, he assured me on impromptu visits to the ward that the Service Manager was very aware of this and that they were as a management team, and everyone was aware of this, and they more or less, everyone was the same, every ward. But I used to feel that because I had patients from everywhere...

191 Q. Yes.

A. But understanding that other wards had their journeys and things that were going on, I wouldn't have been aware of all of them at all, so I had to keep observing. Now it continued much the same. Resettlement was being discussed then, as in resettlement meetings. One ward closed unexpectedly for all of us, and there was a lot going on at this period of time, and resettlement, the pressure on it, I just had never seen the like. Attitudes --

192 Q. So although you've described how resettlement -- sorry, although you've described how resettlement was always a feature of work in Muckamore.

A. Mhm-mhm. Mmm.

193 Q. And it was an accepted feature of what you were doing, are you saying that by this stage the push for it was becoming --

A. Absolutely.

194 Q. Much greater?

A. Oh, yes. And families that we knew well, I mean I had been there now three to four years, I knew them well.

The family members, and some lovely people.

195 Q. Those are the original Ennis patient families do you mean or others?

A. I knew them all, because some of those patients there that came from Killead and Donegore, I knew them from other wards. 12:23

196 Q. Yes.

A. And I knew the families there, and some of them very anxious, all of the time, not just because they had moved, some of them were very anxious because of the movement, and my job in a lot of this was to support the family members. I can remember there was one meeting in the admin block where families, I believe, were raising concern about their patient moving, their next of kin, their daughter. And I think the meeting was rather heated, and I remember being asked to come over fast and to take the parents to see Ennis Ward, which we did. And so, you were always -- every time they came up, you know, we developed a good relationship if the person did move. 12:24 12:24 12:25

197 Q. Can I ask you then just about a feature just in these paragraphs, and a further paragraph. Going back to 83, and I'll summarise what it says, but in 83 you talk about how you began to raise concerns regarding insufficient staffing resources through issuing e-mails, duty sheets and Datix. You say at 91 that on 18th September 2012, that you highlighted on the Datix that staff resources were below what was required for safe management of the ward, and you described the 12:25

dates. And then just looking ahead to 100, please, at page 35, there's just a point I'd like to get your view on. You have set out a quote from 23rd October 2012, where you've included a Datix entry and you describe that in some detail. 12:26

Now, the reason I've drawn those to your attention is because the Inquiry would be interested to know why it was that you felt it necessary to raise staffing issues on the Datix? 12:26

A. Because I felt that this is the one way I can do something about this, and the resettlement team was visiting at that time and activities were beginning to get restricted, staff were still in this way, and I wanted to have it recorded as well where I could, and 12:26 somebody could do something about this, get in agency staff or something. Which wasn't a feature of what happened at that time. There wouldn't have been.

198 Q. Okay.

A. In any ward. 12:27

199 Q. Okay.

PROFESSOR MURPHY: Can I just clarify one thing? What you're telling us, I think, is that at around this time the pressure to resettle became much worse, but also the staffing became less. Now that seems... 12:27

A. Yes.

PROFESSOR MURPHY: ...that seems to me surprising, in that I would imagine that if people are being resettled out that way, there would be more a generous provision

of staff because they weren't being used for those people?

A. Yes. Yes. That is totally right. There was, I think it was called community integration team, it was a new name for the resettlement team. There were people identified in that team only from about then, that time, and you see when 507, is it, came to work, came to be Muckamore's manager, we were told from the off that there were targets -- yes, H507 -- for resettling patients. It was nothing new to Muckamore staff. So that's all right. We felt quite able to do that. But I feel that those meetings were pressurised, that the staff in those meetings, not necessarily the nurses that were attending on behalf of their patient, they didn't -- they weren't at other meetings, they were there to discuss and give information as to what that person would need, you know. But it was the team members, I felt it was a real -- I thought why do they feel like this? What is this, you know? Because they were meeting -- the families of our ladies, as it was in Ennis, you know, came from all backgrounds, and understood, you know, what should be available, and would have had this in their mind coming to this, and needed a lot of time. But they were meeting, I believe, pressure to chose a place. And the thing was whenever you're offered a placement, you may be only offered one. Now if I'm going to look at a house, I want a bit of choice. I want to know where I want to live, you know, who is living with me, who is going to

12:27 12:28 12:28 12:28 12:29

be looking after me? And, yes, those conversations about carers very much are discussed. But, to be honest, what we saw, what came into Ennis wasn't a picture of the resettlement persons, for example, we had seen before. They were a very young team, for example, and it was going to happen fast, and that was not the nature of resettlement in Muckamore all my time. It was very carefully put together, and all of a sudden I felt the pressure, and I am aware of others in my position who remarked to me about meetings, and not only nursing, that medical might have felt this too. You know. 12:30 12:30

CHAIRPERSON: Can I just ask going back to the staff shortages, you raised staffing by emails with your managers? 12:30

A. Mhm-mhm.

CHAIRPERSON: You then raised them through Datix?

A. Mhm-mhm.

CHAIRPERSON: Who did you think would be reading your Datix reports? 12:30

A. Well, when there's serious incidences, you would get a telephone call from the team, whether it's risk and governance. So I thought 'Well these are reading this as well'. I was also giving copies of duty sheets to my manager to show that we could not cover this. 12:31

CHAIRPERSON: And did you get any response? When you entered this problem on Datix, did you get any response at all?

A. No, none.

CHAIRPERSON: Right. When you didn't get a response, did you think there was anywhere else you could go?

A. Well, it was a rolling train. Community staff were coming in, I'm looking around to see the nurses going so fast, I'm talking to my manager who did come in, but he would just say every ward is the same. Every ward is the same. And I thought, we are meant to -- and, you know, we were dealing with things like ringing to the office to another sister who is doing the job that I do sometimes, and we were having to say 'we need seven on the morning', and I know nurses that did that, and the nurse -- well, there was a problem with that because the nurse on the ward was saying 'We need seven', but the nurse down there said 'You're only getting this much, I can do this because'... 12:31 12:31 12:32

CHAIRPERSON: So having raised it with your managers, having raised it on Datix?

A. The Service Manager.

CHAIRPERSON: Yep. It doesn't sound as if you thought there was any other avenue, as it were, that you could -- 12:32

A. Oh, I would know other avenues, but I didn't feel -- and I felt that that -- the next thing I could have done probably, you know. I mean I've been --

CHAIRPERSON: Would have been what? 12:32

A. Well, was to go higher in the Trust and then to whistle-blow. RQIA.

CHAIRPERSON: Right.

A. Those are all in my head. We were having RQIA

assessments in the middle of all of this, you know, and we're telling the numbers. They scrutinised that from the first week after allegations were made.

CHAIRPERSON: Okay.

A. So that could have been -- because I would have read reports. I've read things before, and people could have -- you can go on to do other things. I was completely aware of that. But really those allegations happened just before that. 12:32

CHAIRPERSON: Yep. Sorry, I'm going to take you back to the RQIA. Are you telling us you specifically said to Inspectors from the RQIA that you had staff shortages? 12:33

A. No. Only after the -- when they asked me what I had done about the staffing. 12:33

CHAIRPERSON: Oh, I see. Okay.

A. But they would be aware in any inspection, and we would have had inspections of what we had, but I don't remember -- I didn't ring anybody up.

CHAIRPERSON: Okay. Dr. Maxwell. Sorry. 12:33

DR. MAXWELL: So I have two questions. Firstly, did you think of contacting your union?

A. My union.

DR. MAXWELL: Or professional college, whichever you were associated with. 12:33

A. At the time I was in Unison and, no, I hadn't.

DR. MAXWELL: Okay. That's fine.

A. But it was quite a -- it was a queue of months, but I would understand that I could have.

DR. MAXWELL: That's fine. My second question is: was this that you had the funding for enough staff but you had lots of vacancies or was it that the ward wasn't funded for enough staff?

A. Really, at that stage the manager discussed that with his Service Manager, they discussed that. I wasn't part of that. 12:34

DR. MAXWELL: But as the ward manager you would know the number of staff who were supposed to be employed on the ward. 12:34

A. Yes. Oh, I didn't have enough as far as my --

DR. MAXWELL: Another way of putting it is, was there a high vacancy rate?

A. Well, yes, but...

DR. MAXWELL: And so the issue may have been about the general inability to recruit enough nurses. So even if more money was given, would you have been able to recruit enough nurses? 12:34

A. Well at that time, yes, because it was still that everybody wanted to do their training there, they wanted a job there. 12:35

DR. MAXWELL: So we have heard in other evidence that at some point there was recruitment a freeze.

A. Yes.

DR. MAXWELL: That people could only get temporary jobs. Was that after this or was that in place at the time? 12:35

A. That was after that. That was, yes, maybe '14/'15, I'm going to say.

DR. MAXWELL: So that was later?

A. Mmm. Yes.

DR. MAXWELL: Okay. Thank you.

200 Q. MR. MCEVOY: Okay. So, A12, over paragraphs 93 and 94, on 32 and 33, you describe a process or programme with In-reach by staff from Bohill Care Home, and you describe what the implications of that were and the consequences of that were for how things were going in Ennis Ward, and I think summary we can say that it didn't go very well. Would that be fair to say? 12:35 12:36

A. Ehm, yes. Mhm-mhm.

201 Q. And you say then at 94 that it was obvious from observance that when Bohill staff were present on Ennis Ward as In-reach the patients' behaviours began to deteriorate? 12:36

A. Absolutely.

202 Q. In a sentence or two can you give us an idea why that was?

A. Well, it wouldn't be because of the personality of the Bohill staff, it would be because of the presence of unfamiliar staff. 12:36

203 Q. So nothing personal to the staff themselves?

A. No, I don't think so.

204 Q. Yep.

A. So there was a lot of patients who had autism who didn't speak. They're very routine based, you know. And their routine was, you know, they could be flexible and they could do that to go on trips and things, but to get up in the morning, to move, they don't want to 12:36

wait. You know, they've their own idea of where they want to go and when. And when you bring staff like that in when you don't have the staff, that's, and has proved, a recipe for disaster.

205 Q. Was there no consultation with you about the decision or the idea to bring Bohill In-reach staff into your ward? 12:37

A. Yes, and from the moment -- there was meetings on the ward before they came in and I pointed out at a meeting --

206 Q. Was there any -- I was going to say that, was there any discussion around considering what the implications might be, given the type of patients that you had?

A. The e-mail that I sent, and I rang Mr -- in the absence of 377 -- and I rang and discussed it with -- I can't see the name. Oh, H77. 12:37

207 Q. Yes.

A. That this couldn't happen, that we didn't have the resources. And that was pre the staff coming. The meetings were ongoing, if you understand, your meeting to talk about how you share information and care plans, but before the staff came I was saying we can't do it, but it happened anyway, and it happened anyway. The pressure that I felt around from that team, who were involved in resettling, was high. I don't know how other people felt, as in families, but it was, and it was not backtracking like -- there was redeployment meetings on as well. It was -- we were being told by 507 -- 12:38 12:38

208 Q. Just so we understand, just before you go on, so we understand your evidence correctly, are you saying that you had alerted those when you were in the meetings?

A. Oh, yes.

209 Q. That In-reach by the Bohill staff could be a problem? 12:39

A. Yes. Yes, there's an e-mail or a copy of a minute, minutes of a meeting, it was a resettlement meeting, and at that there was a consultant -- I name somewhere in this all the people that were at that meeting -- and first of all that was about the behaviours of the 12:39 patients that were deteriorating.

210 Q. Yes.

A. And the consultant at the end said 'Will you please make sure everyone knows who wasn't there that day that this is minuted'. So that was prior. 12:39

211 Q. That everyone would know what, sorry?

A. Sorry?

212 Q. That everyone -- who was saying -- who was saying --

A. Everyone knew about the patients' behaviour deteriorating fast. 12:39

213 Q. Right. You were saying this?

A. I said this.

214 Q. Yes.

A. And I could see it. Nurses were telling me. And I took it to a resettlement team to say this, and this 12:40 was before the staff actually began.

215 Q. Yep.

A. And then, then I sent in around that time an e-mail to say to my own management that this couldn't happen,

that we couldn't run a resettlement programme which is introducing people to patients, showing them all their daily living skills, if we didn't have the staff.

216 Q. Okay. And you have those emails?

A. I do. 12:40

217 Q. And you'll be able to provide those to the Inquiry?

A. Yes, I can. But, so -- now, my manager wasn't there when I sent that second e-mail, the one about the resettlement could not happen. He was on leave. And that was -- but I sent it to -- because I rang H77 and 12:40 he said 'this sounds valid', and he asked me to put it in writing.

218 Q. Mhm-mhm.

A. Which I did, and sent it to him, and then he sent it to 507. 12:41

219 Q. Yep. You describe that at paragraph 95?

A. Right.

220 Q. Yes.

A. So she waited until my own manager came back.

221 Q. Yep. 12:41

A. And then it is maybe a week or two before then he sends an e-mail to say 'What's this all about?'.

222 Q. Okay.

A. So. And at that stage he then suggested a meeting with another senior nurse manager, where I could get staff. 12:41 All of the wards -- there was three wards in particular that had the resettlement team in at the time. We did understand that the staffing was also complicated everywhere because of this, and it wasn't just in

Ennis.

223 Q. Yes.

A. So, you know, I don't know do they just think this is just the same. But it was at that stage anyway, it was kind of about the same time, it was just too quick. The senior nurse managers agreed to give staff to Ennis, and I went on holidays, and those staff were not in, would not have been in by the time I came back, and I was on holidays and I got a phone call to say there was allegations made by community staff. 12:42

224 Q. Okay. And you go on to detail everything then, and you've described everything in considerable detail in the following paragraphs then, and you describe how the investigation commenced at around and about paragraph 105 on page 36, and the effect of all of that on you. 12:42

Picking it up at paragraph 108 on page 37, you say that:

"24 hour monitors were put into Ennis Ward. Monitors were Band 6 or above nurses or social workers, although they were not always learning disability trained. Monitors were supernumerary and they did not assist the staff on the ward, they only observed the staff. This made for a terrible atmosphere on the ward. It was unsettling for patients and I do not think it was an appropriate method to deal with the situation." 12:43

Thinking back to that time, how do you think that the

staff on the Ennis Ward could have been supported?

A. Well, I remember ringing Unison. I have been in Unison and RCN both because of a slip where one didn't visit early and I ended up in both. So I rung Unison first and Unison had agreed to come. I had been asking my managers -- to be honest from the moment the Ennis investigation I felt like an outcast. I was stuck in the middle. I was watching staff who were already exhausted now being watched. People coming in, experts from this and from that, who, you know, seemed to be -- well, they weren't under the stress that the staff were, and saying things that I might never have heard from them before, and we had to absorb this. 12:44 12:44

225 Q. Was that -- what I'm asking to you think about with the question is not so much obviously the individual things or the pressures that you were under, because you've described those very clearly, but it's about supports that could have been put in place. What do you think could have been done? I mean I know there's a certain element of hindsight. I'm asking you to -- 12:44 12:45

A. I think the management at the time should have been visiting the ward.

226 Q. Yeah.

A. And they should have been also perhaps offering staff some help. Staff asked me for that and, you know, I was the one that I just felt -- you see I felt because when RQIA asked me about the staffing, I was able to hand all of the things I had done, I had already printed all of that off. When I knew that these 12:45

allegations had been made and I handed this to them, and from then on I was told 'You're not popular down more or less in the admin', RQIA were focused very much on asking management questions, after a good day in with myself.

227 Q. Well did -- I suppose pausing there. Did the RQIA offer any one-to-one sessions with you or ask to speak to you one-to-one or any of your colleagues?

A. Oh, yes, I was -- indeed, they did. There was three ladies from RQIA there, and then they also spoke to my manager, and they spoke to the Service Manager all probably on that day, and they may have been back a few times as well to speak to me, but then they after that focused on management.

228 Q. Did you use that opportunity to indicate to them issues you were experiencing concerning staff shortages?

A. Absolutely. Mhm-mhm. Not only that, some of the -- I was never privy to the allegations that were made in Ennis, but I can hear. I could hear comment from this one, that one, and the other, and then they were asking me for things 'Will you please give me so and so's notes?' And there was, for an example, I would have been able to know what was happening the day before and then I could pick up that someone's mouth had blood on it.

229 Q. So -- and I'm just summarising here, but when the RQIA were speaking to you, it was with a view to getting your account of individual instances or...

A. No, they wanted information, and I just had to give the

information. It wasn't that things were shared for me to understand.

230 Q. And did they -- you weren't asked at any stage then for an account, sort of an open-ended question along the lines of; how have things been for you in here? How are you findings things? 12:47

A. Oh, yes, they did.

231 Q. Yes.

A. There was one lady very good and she listened and took time and -- she did, indeed. 12:48

232 Q. Yes.

A. So by the first day they came in, there was three, you see, personnel from RQIA, and it wasn't -- but then she would have come back another day and spoke to me myself at length. 12:48

233 Q. Yeah?

A. And, yeah, they did.

234 Q. Okay. Well, coming back to the monitors issue that we had touched on a few moments ago, at paragraph 112 on page 38 you say about five lines down: 12:48

"It was the very presence of monitors accounted for a sharp rise in patients' behaviour. Behaviours were triggered again that patients had not exhibited in a long time. It was very sad. The ward was chaotic. 12:48 There could be four or five new faces in the ward every day, each relieving the other for breaks. Autistic patients appeared confused and were frightened. They lost their routines and some dignity. This was evident

in the chance of behaviours. One female patient exposed herself when she saw a male monitor. I reported this to management to request male staff would not monitor this patient in her sitting room. Some patients withdrew while others regressed totally. I reported this effect and reaction of patients, but both visiting and monitoring continued, it was though no-one was listening."

So I suppose suffice it to say that the effect of monitors on Ennis was presumably not what was intended. How do you think it could have been done better?

A. By having the monitors there?

235 Q. Or not, as the case maybe. How, looking back on it, how do you think things might have been done?

A. Well, I don't have an answer as to how you would do it any better. There were no cameras in Ennis Ward, but it was a complete disaster. It reduced -- all of the work, the progress that the patients and we, the nurses, had made was reduced. Went back years.

236 Q. Yep.

A. And, you know, I'm talking about a patient who was in one of these "onesies" that someone has described, and she wore them because she every day removed her clothes, put them out the window. Removed the hair from her head. She was bald. By the time she spent -- she came from Fairview to Ennis, and her hair had grown. She was wearing silk blouses bought by the staff that was in that ward, that have taken tremendous

insults through all of this. She wore them. She kept them on. And when I'm listening to all these questions, and seeing an investigation ensuing in the ward, I'm watching her throw those clothes out the window, pulling the hair out of her head. So there we go, right back. And it didn't -- those things weren't achieved in a day. You know learning disability nursing, things take a long time to achieve progress, and progress - - I knew those patients from the day and hour I started, the ones that came from F4, because I had been there as a student. So I knew what they did, I knew their environment and their conditions. But here it was all out the window. 12:51 12:51

But to get back to -- I don't know what reassurance people needed, because for a start I didn't know the acquisitions or the allegations. So, you know. 12:51

CHAIRPERSON: And are you putting that deterioration, just as an example, of that patient's behaviour, directly down to the presence of monitors? 12:52

A. It steadily went up. In the beginning when you don't have enough staff, yes, you can see they're not getting as many activities. Whenever the unfamiliar staff in the form of Bohill staff came to visit, oh, definite notice of more incident forms, I felt, noticing -- but nobody wanted to know this. Whenever the investigation then, the allegations were made, I was pointing out that I had been telling about this behaviour, and then when it did happen, but that was in the form absolutely 12:52

of monitors. The monitors, you know, I can remember many of them, some were from in the hospital, some out. Some from the other end of the North, social worker maybe, you know. So, absolutely. They were coming in to an environment -- there might have been five monitors in a day, maybe seven, and that's because everybody had to get a break. And, you know, when you had a break they weren't leaving the hospital or the ward unmonitored, so another one would come in, and when they came in I had to induct that monitor, because many of them weren't from the hospital, and then, you know, the patients, some of them actually, some of them -- I'm telling you more of the front of the ward -- actually enjoyed seeing the staff that they knew, but it was the most degrading experience for nurses and the most invasion of privacy for patients that I have ever seen.

12:53

12:53

12:53

CHAIRPERSON: Yes.

A. There had been no investigation that I can compare in the hospital and, yet, I would have been aware, they have had to manage allegations of abuse before, you know, I never seen the likes of this. So I couldn't understand it. I felt there was an agenda from that point. I was walking through the ward thinking there's something wrong, these nurses are performing like this, I'm telling them it's like this, and all of a sudden everybody is being made to feel low. One whispered in my ear 'I'm afraid to lift my head to follow the patient'. So they were pushing patients round in

12:54

12:54

wheelchairs feeling every movement. Putting sugar in a drink. Everything could be questioned, watched.

CHAIRPERSON: Okay. That probably would be a good point for a break. It doesn't look to me as if we're going to get any reading done today, and that is absolutely fine, because I think it is important that we give this witness as long as you need. So, we'll break for a bit of lunch. I'm going to ask you again, please don't speak to your supporters about the evidence. And I think lunch has been or will be brought in for you, so you don't need to leave the building. So we'll see you back at about 2:05. 12:54 12:55

A. Sorry, 2:30?

MR. MCEVOY: 2:05.

CHAIRPERSON: 2:05. 12:55

A. 2:05. Okay. Thank you.

CHAIRPERSON: Thank you. If you'd like to go with the Secretary to the Inquiry. I'm not that generous, I'm afraid.

12:55

LUNCHEON ADJOURNMENT

THE HEARING RESUMED AFTER THE LUNCHEON ADJOURNMENT, AS FOLLOWS:

CHAIRPERSON: Thank you.

237 Q. MR. MCEVOY: So A12, taking it up at page 41, and paragraph 119 and following, you describe your experience in and around the Adult Safeguarding Investigation, and your experiences as well, and your impressions of those, particularly, your managers towards you. There are just one or two points within this section of your statement that I'd like you to focus on for the moment, please. 14:03 14:03

Looking at paragraph 121, which is about two thirds of the way down, you tell us that: 14:03

"During a meeting with managers from other departments, I recall H507 remarked that..."

-- I think she's addressing you directly: 14:03

"RQIA are not our friends."

And then you say: 14:04

"From the outset of the Adult Safeguarding Investigation, when I was asked by the RQIA what I had done about the staffing, I realised this was when I had become to be grossly unpopular with management."

Now, first of all, can I ask you, are you able to tell the Inquiry when that meeting took place, approximately?

A. Yes, that would have been just as the investigation begun, so it could have been December 2012. 14:04

238 Q. 2012. Do you recall whether anyone else was present at that meeting?

A. Oh, yes.

239 Q. And can you recall -- you have the cipher list beside you, can you recall whether any of the names on that, 14:04 if those individuals were present, and if you can give us them, please, if they are, or if they were?

A. Well, I remember the four other people that were at it and that was H351.

240 Q. H351. 14:05

A. And then H507.

241 Q. She's the maker of the remark?

A. Yes. Sorry. And then -- I'm unsure if you will have them listed.

242 Q. If there are other names you can write them down on a 14:05 slip of paper that the Inquiry Secretary will give to you.

CHAIRPERSON: I think when we do this, which is fine, we will have to allocate new ciphers and then let CPs know the true names, unless there's very good reason 14:06 not to.

MR. MCEVOY: Yes. That's right.

A. If I can't see the name or remember it --

243 Q. Just write the name.

A. I know the person, but I maybe can't remember --
244 Q. Of course. Just write the names down for the time being?
A. -- those names.
245 Q. Yeah. Write the names down for the time being and then we can deal with the point. 14:06
A. Deal with it after. So it would have been the -- I've got one.
246 Q. And please try not to say it out loud.
A. No. Another one. And that's -- (SAME HANDED) 14:06
247 Q. Okay. Thank you very much. I want to ask you about that remark. What was the context in which it was made?
A. Totally out of the blue.
248 Q. Right. 14:06
A. And the meeting was about improving the ward, which was very ironic because I had made attempts to do a number of things, and some of the things in the beginning were done, but it was becoming increasingly obvious. We knew the ward was closing and that those requests, even 14:07
like a cracked floor, could not be replaced. No new curtains. A lot of those things turned out to be criticisms in the Ennis Report I think, and, yeah, it was -- I didn't say -- I wasn't talking about RQIA. It came out of the blue "RQIA are not our friends", and I 14:07
didn't understand it.
249 Q. Okay. And what did you surmise was the reason for her saying that to you?
A. Well, again, I just thought they're under pressure,

management, from RQIA about staffing, and that was it. I mean I was told a particular --

250 Q. And you go on --

A. I was told that members of the RQIA were frequently in the nurse administration and they were really asking a lot of questions. It mightn't have been in those words I was told, but it was to that effect, and at that time I wasn't seeing so much, but that came out of nowhere. 14:08

251 Q. Now you make the point in this paragraph: 14:08

"When I was asked by the RQIA what I had done about the staffing..."

Did that discussion in which the RQIA asked you that question take place at or around the same time in December 2012 or was it at some other time? 14:08

A. You mean when I was asked by the RQIA when had that--

252 Q. Yes.

A. That was immediately after the allegations were made by the Bohill staff. 14:08

253 Q. So that would have been prior to December 2012?

A. Yes, it could have been end of November, but I'd say it was December that meeting.

254 Q. Right.

A. It was after they had asked about staff. 14:08

255 Q. Right. Okay. In the following paragraphs you detail the issues that you encountered, as I indicated, with your colleagues, and particularly with management and, indeed, then you describe your sickness absence and the

reasons for it, and you describe some of the symptoms that you have, and I'm not going to open them in any detail, but essentially your experiences while the investigation was going on.

14:09

Now, could I ask you just to turn then to page 48 and to paragraph 136? And in 136 you summarise really the experience that you and your colleagues in the Ennis Ward, the staff, had to face. You were working under great pressure with insufficient resources. As a result of the investigation you were coping with patients who were clearly upset by the chaos caused by the introduction of monitors, which we talked about before the break, following the introduction of visiting staff. You talk about how the Ennis Ward staff team was unsupported and exhausted:

14:09

14:10

"Such was their compassion..."

-- you say:

14:10

"...that they reported being afraid to have fun or even have normal interaction with patients. Patient activities provided by nursing staff were fantastic in the Ennis Ward until staffing resources were not met. It was that simple."

14:10

You then observe the Leadership and Governance Review conducted by the Health and Social Care Board in 2020

states that there was, you're quoting:

"...little evidence of patient activities. The absence of activities resulted in boredom, a lack of stimulation, and served to contribute to the management challenges of caring for patients with complex and at times conflicting needs." 14:10

That's the end of the quote. And then you say that Ennis Ward staff did not deserve this. You say that: 14:10

"The review refers to a culture of institutional abuse in Ennis Ward, in other wards, and then in the ICU. I feel it was harmfully misleading to suggest that the perception of the visiting staff in Ennis Ward was linked to the report of physical assaults in the ICU." 14:11

And you make reference to how photographs evidence the sheer joy and quality in patients.

Now, do you think that the events of 2012 and the report and investigation was just down to staff shortages, or was there something else? 14:11

A. 2012?

256 Q. Yeah. 14:11

A. Totally inadequate staffing, because I knew I was satisfied and happy with the care being given up until we had no staff and, yes, they were closing the ward and, yes, the environment, I couldn't get things, and

they mention that, so that was true. But the very fact and, you know, my colleagues, their memories of this too, you know, is, there was no staff.

257 Q. Yeah.

A. And, you know. And to expect people to deliver the care with that, you know, part of my job, one of my main roles is looking for -- is monitoring patient care and safety. So like this is number one. 14:12

258 Q. But it boils down to not enough staff.

A. And it was very obvious, you know. I mean every ward before that, doing that, even as a Staff Nurse. 14:12

259 Q. Okay. At 137 you then discuss the Ennis Investigation and the resulting report. Now, the Inquiry is going to hear more detail about this report in the next short while, but in your statement you have detailed your observations about it, and I was going to give you an opportunity just to comment upon it. But what you do say in the body of your statement is that you were surprised that a lot of the information you had provided to the investigating officers during the Ennis Investigation was not included in the final Ennis Report. And you say that you were astonished that a nursing team could give so much of themselves to be judged so cruelly and by few who had ever worked a shift in the Ennis Ward. And then you have a list of what you say are omissions from the report. So I'm just going to summarise these and start at the top of page 49. 14:12 14:13 14:13

The report didn't record that the patients in Ennis Ward were already unsettled prior to the commencement of In-reach by Bohill staff, and you go on to explain that and expand upon it in your statement. You then go on to say that the Ennis Report did not highlight the effect that the In-reach staff had on the patients on the Ennis Ward, which is something we talked about this morning. 14:13

CHAIRPERSON: Sorry. I'm so sorry to interrupt, Mr. McEvoy, but just going back to the previous point, I think you make it clear that what you were talking about prior to the commencement of In-reach was your bitter complaints about short staffing. 14:14

A. Mhm-mhm. It was impacting them.

CHAIRPERSON: Sorry, Mr. McEvoy. 14:14

MR. MCEVOY: Yes. So it's the second sentence:

"I previously highlighted and stated in my earlier statement that I was complaining bitterly that I was already short-staffed."

It's the second bullet point:

"The Ennis Report did not highlight the effect that the In-reach staff had on the patients on Ennis Ward." 14:14

And you reference a meeting then about resettlement and explaining to that meeting that the patients in Ennis Ward were feeling unsettled because of the unfamiliar

Bohill staff on the ward and some steps to deal with that.

You then go on to say that when the In-reach had begun you recall a Senior Staff Nurse, H487, coming to you 14:14
one day to explain that the In-reach staff had not arrived on the Ennis Ward and a Senior Staff Nurse explaining that on other days four staff had arrived all at once, too many for the patients and staff to manage. Many of those patients had fixed routines, 14:15
autism and other neuro-diverse presentations, and they were easily agitated. Changes altered their routine. And you explain that in quite a bit of detail overleaf as well, on the top of page 50 and following.

14:15

Then you go on to talk about the practical difficulties in managing and working with the Bohill staff. If the Bohill staff, you say, were not elsewhere in Muckamore, to contact the Bohill manager and explain no-one had arrived and advised her that this had happened on other 14:15
days also.

You then go on to say in the next bullet point that:

"A number of Bohill staff felt that they should not be 14:15
taking the particular patients who were identified by the resettlement team. The Bohill staff suggested other patients and said this in front of patients who were identified for resettlement."

You observe that those were the most vulnerable patients that you had and that:

"...they had challenging behaviours but the staff were so familiar with them that there was rarely an issue until the staffing resources were depleted so severely that the place was chaotic, and particularly when the Bohill staff were arriving in high numbers." 14:16

14:16

And you then say that this had the effect that a number of the Bohill staff did not want to work with the patients who had been identified to go to Bohill with them, and then you say that you took steps to address that by advising Bohill staff should report that to their manager and so on. 14:16

You then make the general observation in this section in conclusion that:

14:16

"The Bohill staff were a really young and inexperienced team in general, exclusive of the manager."

You recall you met one enrolled nurse and the remainder were nursing assistants who were school levers. 14:16

"They were certainly not experienced in managing severe challenging behaviours. They were seeing the disturbance on the ward, patients' routines were upset

due to their presence, I understood this could be frightening for them."

Did you have an opportunity to articulate those points to anybody in management and senior management? 14:17

A. No, because I went on leave, so I was securing staffing and that meeting. There were meetings, I think it was fortnightly, and that would have been when I came back, but that was after allegations were received.

DR. MAXWELL: Can I just check? When the team who were investigating drafted their report, were you given a chance to fact check the report before it was published? 14:17

A. Oh, no. We just had an interview with them and, actually, I was ready to talk all day -- you'll be getting worried! But I was. 14:17

DR. MAXWELL: But when they had written their report, they didn't send you to say 'Have we got the facts correct?'.

A. Not at all. I had to ask for the report. And the e-mail, I considered it to be ignored because it wasn't responded to. When I knew it was out, you know it was available, it had been done, which was a number of years later, you know '15, three years later, and I had never known the allegations, and then I never knew about the report, anything about it, until I asked. So the e-mail wasn't answered. I wanted to meet with Service Manager, I wanted to know everything about this whole investigation. Part of not knowing things makes 14:18 14:18

people ill, I learned this. And then when I -- I had to ask the RCN, who typed out a letter, sent it to her, and then she agreed for a meeting, and at that meeting then she shared a report with me.

DR. MAXWELL: So it was only after the RCN had written and asked that you saw a copy of the report? 14:19

A. Absolutely. In 2015. And that was maybe October, and this had --

DR. MAXWELL: October 2015?

A. Yeah. And it had occurred, you know, well you know 2012. So all of that not knowing took a real -- this is why I went on about my health, because this is the result of that, not knowing and understanding things, when you are interested and passionate about your job. If you're not, you mightn't care, but I was. I mean I put a lot of work into it. So, yes, it was then by that stage. 14:19

DR. MAXWELL: And you were being supported by the RCN at this point?

A. Yes, I had moved from one to the other. 14:19

DR. MAXWELL: So did you -- did the RCN, on your behalf, put a response in around this or did you just accept it and not make any comment?

A. Oh, they didn't. Now, they didn't do that. And I read then, I felt, because it wasn't a long meeting, went down most of the things, and the RCN asked 'Well, you know, what is the outcome?', and 507 said, you know, 'You've nothing to answer for', and that was it. I left the room with a copy of the report, and I read, 14:20

and I wasn't happy with a couple of the things, and I didn't make redress at the time, and I wished I had, you know, because I kind of thought they were put in because it suited, because there was -- I always felt there had to be something to pin this nurse, to pinning this nurse, and I felt there was a couple of things I wasn't happy with. I can't remember them now, but one of them was in relation to staff/patient ratio, or staffing. I mean, my goodness, I had been making duty rotas out for years and nobody had ever mentioned anything, and all of a sudden this has slipped in here whenever I knew that the management were not happy that I had done things and had presented it. That's how I felt. There was nobody on my side, apart from the staff on the ground, you know. 14:20 14:20 14:21

DR. MAXWELL: Thank you.

A. Thank you.

260 Q. MR. MCEVOY: At 138 you say that:

"As the Ward Sister of Ennis Ward I was not given an opportunity to voice my thoughts to the team who wrote the Leadership and Governance Review in 2020, and as Ward Sister on Ennis Ward at the time that the allegations were made in 2012, I was not interviewed by the Leadership and Governance Review Team." 14:21

Did you raise that apparent oversight with anybody?

A. Yes. But you understand this is when the report came out?

261 Q. I do.
A. I didn't know when the report was coming out or finished, and when I got a copy I remember reading it and I wrote all the things down then, I still have that downstairs. 14:21
262 Q. Yes.
A. And I then wrote to my then manager, who is in this somewhere, and he then forwarded that e-mail to another, the Learning Disability Assistant Director, but I heard nothing more. So it was H230 is my manager 14:22
at the time, and there were two Assistant Directors with a similar first name I think, one after the other.
263 Q. Mhm-mhm.
A. So -- but the letter, the letter explains who that was, the e-mail. But that was just to say that I had -- 14:22
that report, that bit of it in Ennis for what we had done, and it wouldn't have read like it did if I had the chance to explain. And the problem was I did read, when I read that review, and I believe it's right, that they based their Ennis portion on the Ennis Report, and 14:22
the Ennis Report to me was neither full in content or accurate.
264 Q. Yep. For the reasons you've given.
A. And grossly lacking. And a lot of the stuff then that I was able to. Then, to be honest, coming here has 14:23
given me an opportunity to do that. There was nowhere else.
265 Q. Okay. Right. Okay. So there was, other than raise it with your line manager then, there was no-one else with

whom --

A. Yes. Yes. And then the assistant learning disability, she didn't come back.

266 Q. Yes.

A. But it was after the event anyway, you know. I mean the report was out and about, you know, they were having meetings and, you know, I have been through this process, I've met people who say, 'Yes, I've read the reports', and I'm thinking 'Yes, you've the reports'. 14:23

267 Q. Yes. 14:23

A. 'But do you know?', and the answer I think was "no".

268 Q. So you didn't get a response then through your raising of the matter with your line manager and his then subsequent escalation of it?

A. No. 14:23

269 Q. You got no formal response or explanation as to why you hadn't been spoken to by the team?

A. No. No. No. Or assurance that my commented went further than that to anybody else in the Leadership and Governance, if that's the title? 14:24

270 Q. Okay. Looking at paragraph 140 at the bottom of page 51, you say that:

"The Leadership and Governance Review..." 14:24

-- you quote from it:

"States that the examination of the Trust's Corporate and Principle Risk Register found no reference to the

staffing crisis at Muckamore."

And following that quote you then say:

"I could not believe this when I read it as I have been raising concerns regarding the gross lack of staffing resources before the Ennis Investigation, during it, and then again before the 2017 CCTV investigation." 14:24

You then say: 14:24

"I had been work in the chaos and assuring staff it was being reported appropriately and believed that the Board was aware too for over eight years. The fact that the Belfast Trust Board did not know of the state of the staffing at Muckamore was the most significant revelation in this review to me." 14:24

Did you expect that your concerns about short staffing and under-resourcing would have made it as far as the Board? 14:25

A. Totally. Because even many years before that I would have understood the managers then would have had, you know, those people came to the site. So there was collaboration. There was liaison. Many of them in those times would have told you they knew the issues, you know. 14:25

271 Q. Yes.

A. Certainly as soon as they came through the door, you

know. So this is very different. Now, the only thing is, all of those eight years it wasn't like that for me wherever -- you know it wasn't always that that was a lack in staff. Because I, I would only put pen to paper like that when I can see risk, and I saw it before Ennis.

272 Q. Yes.

A. And I saw it before the current investigation.

273 Q. Following that part of your statement you then go on to describe over the next series of paragraphs all of the various closures and moves that that meant for you and for other staff and, indeed, for patients throughout Muckamore, and you've described that in quite some detail. I'm not intending to open it or discuss it with you, save to say that it's extensive. But it also then results in you describing in some detail then, again a further period of severe illness and the effect of that on you, and I think anybody who has read your statement will see just how extensive that was, and not intending to reopen that, but I think the Inquiry and Core Participants will have seen the effect of that on you.

But if we could look at paragraph 157 on page 58, please? This is when you return to work after a period of long-term sickness. Totally out of character for you. And you returned to work in 2016 on Killead. Killead by then had moved into the Cranfield building and had been renamed Cranfield 2. You describe how you

were still suffering physical symptoms, you couldn't sit in a chair without getting pins and needles, and a standing table to manage a laptop and so on. But you do say then in paragraph 158 that you were:

14:27

"...motivated now in the business of bringing a young inexperienced new ward team together despite staff being transferred to other wards, as I began to attempt to do this. In parts of the hospital and in Cranfield in early 2017, we had quality network learning disability teams visiting from England."

14:27

-- which you describe as:

"A quality network for inpatient he learning aimed at supporting the wards to evaluate and improve their management and standards of care. At this we shared our current practice and standards. The staff teams spent time in the wards with patients and staff and I was aware the outcome was successful."

14:28

14:28

Now when that, when members of that team were in from England, I suppose they would have been strangers or unfamiliar to patients. Do you recall there being any of the type of issues that were encountered with monitors previous?

14:28

A. None at all. But they weren't having to sit in the day spaces so much. They were walking in and out.

274 Q. Yes.

A. The patients then were very used to that, visitors, families.

275 Q. Yes.

A. You know the families were walking into their next of kin's bedroom and collecting laundry and things. The 14:28
social workers were coming into the ward every day of the week. The meetings were held either in the ward or round the front in the group area where visitors rooms happened to be. So these were professionals who did seem to have a good understanding of learning 14:29
disability. So they were very aware of their presence and how that would be. They were different patients as well. I mean this was an open ward with very capable young men, well not all young, but a variety of ages.

276 Q. Different levels of need perhaps? 14:29

A. Yes, different. It is very different there. Autism, there was some, but, no, they were all quite able. Whereas Ennis was a different environment.

277 Q. Do you know whether that team produced a report?

A. Oh, they did surely. Mhm-mhm. And there was -- all 14:29
very good. They were in a number of wards in the hospital, it wasn't just Cranfield, and the particular core manager would, you know, be aware of those reports, and I know they were 98% up. I don't know -- there was maybe one was a wee bit less, but it was all 14:30
about collaboration and sharing your understanding and your knowledge and, you know, outcomes, and it was very interesting. But I mean that timing of that was significant.

CHAIRPERSON: Sorry, 98% up on what?

A. It says 97%. The report -- well I'm not involved in how this is measured. I was there to hear how the ward was successful or not.

CHAIRPERSON: Right. 14:30

A. And so -- about the standards of care, how they found it, you know, but it was --

DR. MAXWELL: So there was an audit tool for the standard.

A. They had to come in and say -- yes. 14:30

CHAIRPERSON: That's what I understand that they did. That's fine.

A. I was, I suppose, a bit new to the core hospital at this stage, and this had been planned quite a while, this, and I think staff had been over to the UK and 14:31 then coming back.

CHAIRPERSON: Okay.

A. So it was an ongoing thing. So I wouldn't be the best to ask the history of that, but I do know it was successful. 14:31

CHAIRPERSON: Okay. Thank you.

A. And the timing is significant.

CHAIRPERSON: Mr. McEvoy.

278 Q. MR. MCEVOY: Okay. Thank you. So in the following paragraphs then again you describe some workplace 14:31 issues and some of the very significant issues that you encountered and were involved in with other staff colleagues, and particularly with management and, again, both the Inquiry and Core Participants will have

seen that information, and it is -- I think it's fair to say most of it is touching on your relationships with others in the workplace as opposed to issues directly per se of patient safety.

A. Mmm. 14:31

279 Q. Could I ask you then to turn to page -- it'll be page 70, the bottom of page 70, it should be paragraph 184. Now here you say that:

"In 2018 I would have been keen to take a senior 14:32
manager's post as I felt ready for the role. However, in 2018, and during the ICU investigation, management in Muckamore Abbey had collapsed, and by 2019 it was a toxic mess. There were staff in management who had no
experience. Staff needed direction and were not 14:32
getting it from management. There was no longer any leadership by management. Senior members of staff avoided the wards."

Now we don't need names per se, but when you talk about 14:32
"management" in this paragraph and in this part of the paragraph, at what level are you talking about?

A. Service Manager, 2019, which is a different one.

280 Q. Okay.

A. And then senior nurse management level. 14:33

281 Q. Okay. And when you say they had no experience, can you explain a little bit, just a little bit more about what you mean by no experience? Like no experience of what essentially?

A. Well, one of them may be learning disability.

282 Q. Yes.

A. And others no experience of management.

283 Q. Okay.

A. Very little, you know, time, maybe, in that particular role. 14:33

284 Q. Yes. You say then at the end of this paragraph:

"I witnessed injuries to staff with blood on their uniform from the behaviour of patients that was normally manageable. There was a total lack of confidence and discontent amongst the nurses at Muckamore Abbey at this time. It was frightening to be in Muckamore Abbey..." 14:33

-- I think there's maybe an unfinished -- maybe a word missing from the paragraph there, but you can maybe assist us with what you had hoped to put in?

A. It was a frightening time to be at Muckamore Abbey.

285 Q. Yes. Okay. Now, what did you put that down to? In a sentence, if you can. 14:34

A. Well there was no staff, again. But not only that, I mean this now was full of -- it was an absolute nightmare. The patients who were there at that time, you know -- 14:34

286 Q. So you've staff -- sorry, you're saying it's a lack of staff and then you're starting to talk about the patients. Lack of staff is one thing. You started to talk about the patients.

A. Is this '19 or '18? '18?

287 Q. Yes.

A. So it was probably the worst I had ever seen it.

288 Q. Well you've talked about '18 --

A. If I thought Ennis was bad, this was worse. 14:34

289 Q. Just so we're talking about the same thing. You've talked about '18 into '19?

A. Yes.

290 Q. You say that by -- you said in that paragraph that by 2019 it was a toxic mess, so it would seem -- 14:34

A. Yes, it was toxic by that stage. So I had -- I needed a gallbladder operation, and I do believe that was as a result of stress, but here and there it came out, and that was in November to December of '18, so I was absent from the ward. But before that time, before 14:35 that run up to that period is the blood on the uniform, is seeing a colleague next door managing what had been an admission unit with herself, this is an experienced learning disability manager, trained manager, and with a staff on relief from my ward, with someone in relief 14:35 from another ward, and they were trying to cope with behaviours from patients who were frantic. Those patients weren't getting their needs met, as in they would have been getting their food, but they were not getting socially staff who they knew, routines that 14:36 they knew, it was grossly lacking, and at one point I can remember -- so there's a space in between my ward and the other ward, and this one particular day walking over to see how things were, and there was a nurse

standing in the middle, a very -- a young but very capable experienced nurse with scratches. I mean she must have had say 100 little tiny scratches all down her hands, blood coming from them.

291 Q. So this was unusual then in your experience? 14:36

A. Oh, yes.

292 Q. Okay.

A. I mean there was plenty of injuries over my time in Muckamore, but they were mostly manageable situations that came to an end. 14:36

293 Q. Yes. Yes.

A. There was no end to this, and there was nobody giving answers, there was no presence. And then, you know -- even during that time you're raising, each manager that's coming in hoping they will do something about 14:37 it, and it's going higher up the management because it is during an investigation.

294 Q. Yes.

A. So had people from -- that were not belonging to the hospital there, Directors of Nursing, you know, and the 14:37 situation was out of control.

295 Q. Okay. At paragraph 187 at the top of page 72, you say:

"There was a hostile attitude and lack of respect from the most senior members; H282, H355, Staff Nurse H13, 14:37 charge nurse of the ICU team was alarming."

Now you then say:

"It appeared that they were taking their frustrations out on me and did not expect me to be there."

Focussing just on one specific aspect of what you say there just around frustrations, what frustrations do you think they were encountering? 14:37

A. Mmm. Some of them were staff who had been drafted in to ICU to assist to help with the, even more gross situation of staff, I was led to believe caused by suspensions. But then there were others of those staff, few of them had been there in the ICU team, so they weren't all staff who had been part of the team, some of them were staff that came to help. So they were getting becoming familiar, forming a team. 14:38

CHAIRPERSON: Just slow down a bit. Take a breath. 14:38

A. Yes. It's getting rolling away. So they were in the business of trying to make a team, I suppose. I would try and understand how people think before I, you know, sometimes I assess what's going on, and they were becoming accustomed to the manager that they had, and then all of a sudden what happened on them when I was having this gallbladder keyhole operation, then I was coming back to work, I don't think I was expected to come back to work, and this team were being -- they were told overnight -- you see I wasn't there at that time. My understanding is they learned -- somebody walked in -- the management told them on Christmas Eve that ICU would be closing. So, you know, they're people too and they're organising their lives and 14:38 14:39

what's going on, as well as doing a very difficult job in ICU at the time, and then they were moved into, I understand into the ward adjacent to me in the beginning, the staff team was - I don't understand or know why - and then I reported back to work in the meantime, and the manager who had gone to assist as well, plus the staff, and all of the staff, they left some in the adjacent ward, but the rest -- most of them came to me to. Understand that I was complaining for staff, raising concerns for a number of months again, so therefore... 14:39 14:40

296 Q. Okay.

A. I could understand that they felt a bit aggrieved that I would appear on the scene because they thought, I think, he was going to be their manager. 14:40

297 Q. Yep. All right. Yes. Okay. Now, can I ask you then to look across to page 78 and to paragraph 204? Now, if you can just help us understand just the context of this event. So you talk about how in July, at the end of July '19, you received an e-mail from H294 to tell you H296 -- 14:40

CHAIRPERSON: Just pause for a second. Sorry, that's interfering with the microphone. The witness is fanning herself and it is hitting the microphone. We can cool the room down a bit, but don't use the fan. 14:41

A. Great. Thanks now.

298 Q. MR. MCEVOY: So you received an e-mail from H294 to tell you that H296, the Director of Social Services, had requested that you contact her personal assistant

as soon as possible to arrange a meeting with H296 and Brenda Creaney at A Floor at the Belfast City Hospital. You asked what the meeting was about, but you don't recall getting a response. And then there is some liaison with the Royal College of Nursing, and eventually you attend for an interview on the 6th September 2019. Did you understand by the time you attended for the interview on the 6th September 2019, what the purpose of the interview was? 14:41

A. Well I asked what the agenda was, and was told it was about my role. So that was big! And it didn't explain anything. I was going with another staff member who had got the same e-mail. 14:42

299 Q. Yes.

A. Because to be honest, I was chased on to night duty and that is the -- so I am on night duty at this point, and still receiving what I felt... 14:42

300 Q. So you then say:

"We found ourselves in a meeting with Brenda Creaney and H296 in Brenda's office in the Belfast City Hospital." 14:42

You say:

"I was unperturbed. I knew it was unlikely that either of us had done anything that warranted this." 14:42

And then you go on to say:

"I suspect that both of us were being set up whether the directors realised it or not."

Set up for what? 14:42

A. Ehm, blame of whistle-blowing.

301 Q. I'm going to come to that in a moment. Was that what it was that you --

A. Yes.

302 Q. -- were concerned about? 14:43

A. Both involving the RQIA and the other one.

303 Q. Yep. I'm going to ask you about that?

A. And a radio person.

304 Q. Yes. I'm going to ask you about that right now.

DR. MAXWELL: Can I just ask? Were you concerned about 14:43 who you were being asked to meet, because these were --

A. Oh, absolutely.

DR. MAXWELL: -- a number of steps above your line manager.

A. Absolutely! The top of the lovely building over there 14:43 in Belfast, and we would never have been in that hospital for anything only our own illnesses or escorting patient, you know. So this was completely out of line. But understand as well though, both of the two that asked to speak had been on site, had had 14:43 some amount of listening exercises. So we did know who we were talking to, but it was a very rare thing."

DR. MAXWELL: Did your line manager know that they had asked to see you?

A. My line manager? By this stage yes, he did. Mhm-mhm. But they wouldn't have had any -- they weren't given any idea if they knew anything like that. I mean the place was being run by, at that stage interim sort of management was a lady from, not from Muckamore Abbey, and her name will be here, and then my own manager who was a chap that came to work in the middle of all of this, again they were trying to get who they could, and he didn't know. We asked him, but he had no idea. And we asked -- I asked the Service Manager, I have an e-mail, and she didn't know. I think it was her that her initial e-mail came from to say would I contact the Social Services lady about making an appointment. 14:44 14:44

DR. MAXWELL: So these are two Board level directors that you're being asked to go and see. 14:45

A. Mhm-mhm.

DR. MAXWELL: Did they offer you the chance to have somebody to go with you as supporters?

A. No, they didn't. But as soon as I got my email, and I happened to be on duty with the other girl who got an e-mail, and "I've got an email from", and she says "So did I". So then at that point I says maybe we can go together? And then maybe that's how they felt we were getting support. But we did speak to RCN at the time as well and we agreed we would go, and neither of us felt guilty enough to be worried enough, but it was still pretty -- going up there. But then we came away with a clear conscience, because we had one, and it was pretty awesome. It was something to remember. 14:45 14:45

305 Q. MR. MCEVOY: What you recollect from the meeting is that you were asked if you were involved in whistle-blowing incidents involving the RQIA, and a call to an MLA who spoke out on the local radio station. Who asked you those questions? 14:46

A. Mhm-mhm. The one who directed that towards me about the RQIA was the social worker. I just can't remember her name right now. It's in that. And I was thinking as this happened, you know, I remembered one day that during when RQIA had visited the site she had came into 14:46 the room and she saw me with the lady from RQIA, and I thought 'Does she not realise that this is what happens? Ward Sisters are taken aside and asked about different scenarios'. It was nothing that I wouldn't have been asked to before, probably was, about 14:47 staffing, issues that they wanted to know more about, and we would certainly -- that's what you do. And you speak and you tell the RQIA as it is. And I often wondered is that where she thought? And then maybe I'm unaware of some kind of thing that has been raised 14:47 outside from RQIA. So I thought she was putting two and two together in that respect. But I understood it a bit more when I asked why were we there and who? I think it was explained that there were people who felt, and then that's why, it was my colleague asked, who 14:47 were the names, and they explained.

306 Q. Okay. All right. Now, I want to briefly ask you just about something that you have mentioned. It starts really at paragraph 210. I beg your pardon, 211. On

page 82 and it's 211, and it is an issue relating to a patient. Now, I'm not going to -- I'm going to summarise this as briefly as I reasonably can because there's just really one point that arises out of it, but you talk about, and I'll put it this way, an allegation made by a patient's mother, and I'm not going to open what the detail of the allegation was or who was involved, but you had an input into it, and you describe your experience of it, and what happened during it. And you then say at paragraph 212 that: 14:48 14:48

"There were so many allegations made by this patient's mother that the safeguarding team asked for the ward to report everything to them directly at the time so there were no delays in investigating." 14:48

You say:

"I am only aware of the allegations against nursing staff and unaware of the allegations made against other members of the multidisciplinary team. To this day I am unsure of the details of this allegation and if the other staff's allegations were reopened or not. I am unaware if there were any other professionals suspended or put on supervision in the current CCTV investigation as a result of allegations by this patient's mother." 14:49 14:49

Now, you then contrast your experience with this complaint and its out-workings with your experience of

the past, and you say:

"In the past I have known a number of safeguarding investigations conducted at Muckamore Abbey using experience, wisdom, sensibility, good judgment, respect and consideration for staff, accused and managed in a timely manner." 14:49

And then you say:

"Both investigations that I have witnessed in the last decade have been lacking any consideration to nursing staff and have been and are damaging." 14:49

Now, in terms of those investigations, what investigations are you talking about just so that we're clear of the two investigations? 14:50

A. Just the Ennis Safeguarding Investigation and the current ongoing.

307 Q. And the current ongoing situation? 14:50

A. Mhm-mhm.

308 Q. All right. In terms of that contrast that you're talking about between that more recent experience in the past?

A. Yes. 14:50

309 Q. I think it's clear from what you say that one of the key issues is about delay, and you talk about how in the past in contrast things have been managed in a timely manner?

A. Yes.
310 Q. What do you want to say about that, if anything?
A. Well, say I have known and, you know, that there's an investigation ongoing about someone, they maybe moved to another area. 14:50
311 Q. Yeah.
A. They may have been suspended. That would have, may have been if there was something where there was contact with them and a patient. But even one where the patient says 'This man is doing A to Z against me', 14:50 and, you know, I've seen that's went on a while. But it has an ending.
312 Q. Yes.
A. And what's happening, happened in Ennis, the complete not knowing and no explanation and no endings at any 14:51 point of it is enough to have people, if not admitted to an institution themselves, worse. I was very lucky I had a lot of support. But this current one, I just know that the outcome for people, they will need maximum support. 14:51
313 Q. Yes. But you do say then at the conclusion of that paragraph:

"If this reactive mismanagement continues I fear for the provision of care for people with a learning 14:51 disability in the future as no-one will want to work in any learning disability service where they are victimised and unprotected by their employers."

A. It's happening already.

314 Q. Okay. And when you say "mismanagement", again you'll have noticed this theme in my questions that I put mismanagement at what level or levels?

A. Oh. Well, essentially people who aren't there on the wards and above. 14:52

315 Q. Yes.

A. Now, it's because I feel there's no understanding or insight any longer into how -- it seems important -- I have known -- it seems important, first of all, to have experienced people looking after a place, you know, whether its Muckamore or some other place that they develop, more modern, et cetera. There was plenty of modern in more recent days of Muckamore as well. But it seems that that experience must be there. Now, years ago I do remember a man who presided over Muckamore who wasn't, but he had a very strong senior nurse management team who all, you know, passed on their knowledge, and shared it, and we knew it was tight, if you like. But whenever that's not there, and whenever you don't have experience, and then further on up you've places that think you're working in a nursing home and its a hospital, you know, it falls apart, as it did, and, unfortunately, to where we're at now. And it's just unfair that it's being linked, you know, to -- I mean as a Ward Sister I am unaware of abuse that's happened to patients, and I have been going round supporting people at night in that role. But the thing is, well, you know, I maintain, because I was there and

dropping in and out of all wards, that there was no culture of abuse, and that's the thing that I find hard in all of this. Of course I understand there has been abuse to people, and I believe what I am being told, but I'm not told the extent of it. I read that. But I mean if that's the case, you know, I wasn't seeing it, and my colleagues, you know.

316 Q. Okay. Well, look, turning to paragraph 216, which is on page 84, we are looking now at a paragraph in which you discuss an offer of a role to you about, you say: 14:54

"There was a two week period when I was not working waiting on the Belfast Trust to give me a new role and H230 had suggested that I could be a Ward Sister on day duty but because I felt I would be at greater risk of further allegations I declined. I was as fearful as all other staff of being accused of something misperceived by CCTV. At the time all other professionals were avoiding spending time being on the wards. They were all aware of the consequences of being there and just at the time when they were most needed."

Now, at first blush somebody reading that, what you're saying is that you were frightened of being accused of abuse even though CCTV was there to record everything that happened?

A. Absolutely. Mhm-mhm.

317 Q. I suppose somebody looking at that might then say well

CCTV is there for everybody's protection?

A. Yes, but even the RCN representative said to me at the time 'Well there's already these allegations and there is this from, and if you don't do' -- I was being encouraged to go back to work on the wards, after being 14:55
put on to night duty more or less, chased, I wanted to be in my Ward Sister role, I did not want to be on night duty. I hung on in there. I can tell you it was a laugh. And then whenever I was made, there was no choice, there too much going on, harassment for want of 14:55
-- talk about it forever, then I went on to nights. So I realised that nights, it wasn't so bad, because patients are sleeping. You know, if they come in, if you're watched on camera and you're seen on camera there is less chances that you're going to be in the 14:56
middle of...

318 Q. Yes.

A. And what they said to me was one more -- this is when they were encouraging me to take the role. If you had one more, goodness knows where you'll be. So I ended 14:56
up -- this was a heated discussion --

319 Q. One more what, sorry?

A. One more allegation was what she was saying to me. If there is one more allegation, you know --

320 Q. Who was saying that to you? 14:56

A. Well the RCN representative, who was very supportive.

DR. MAXWELL: Can I just ask you? You've said you were fearful of something being misperceived on CCTV. So you're acknowledging the CCTV. What do you mean by

"misperceived on CCTV"?

A. Well, I've learned a lot about perception. I came away from the Ennis Investigation understanding that people think obviously differently. But how some people perceive things when they don't have experience, knowledge, they're not there on the wards, it's very differently to people who are. But when it comes to -- you're asking me here about this CCTV and something that's perceived, I absolutely understand -- I am not aware of any abuse, I have not seen any footage, including something I would like to see where I must be part of it, seen as part in this footage -- so I believe that there must be a lot of misperception and I do wonder, I would like to know who viewed the footage, you know, those questions, because I know my own, I know the two dates I was given, and I just want to see, to be able to explain, because I think some of these things, you need to be able to explain why someone was there. And to not to be able to explain from 2020 to now is an absolutely horrific thing to do to anyone. 14:57 14:57 14:57 14:58

DR. MAXWELL: So just to be clear, you think some of the people who are viewing the CCTV don't have the experience of working on the ward and may have interpreted that in a way that you don't think is fair?

A. Possibly. 14:58

DR. MAXWELL: Thank you.

CHAIRPERSON: I think the witness may just have --

INQUIRY SECRETARY: Yes. Can we just pause. I think there may have been the use of a name? So I think we

maybe need to just --
CHAIRPERSON: Yes. Well we can stop the feed I think. All I'll say is cipher list. And that part of the transcript published and the feed to Room B was stopped. Okay. Let's carry on. I think somebody's 14:59
phone is going off. Just pause for a second.
MR. MCEVOY: Well, A12, I don't have any more substantive questions for you, save to say that I note that what you say in the very concluding substantive paragraph of your -- penultimate substantive paragraph 14:59
of your statement, which is 231 on page 89, and you describe your feelings about your chosen profession and about nursing, indeed, at Muckamore in particular. I don't have any questions arising out of it. It may be that you want to add something and that's a matter for 15:00
you. But I am going to hand over in a moment or two to the Chair and to the Panel, to see if they have any questions for you, it's just in case you want to add anything that's said at 231. I think Dr. Maxwell -- before you do, Dr. Maxwell may have a question for you. 15:00

A12 WAS THEN QUESTIONED BY DR. MAXWELL AS FOLLOWS:

DR. MAXWELL: Yes. So I've got just a few questions for you. So in going right back to the beginning of 15:00
your statement, paragraph 23 you say that:

"Safeguarding training changed to vulnerable adults in 2012 when a new policy was introduced."

A. Yes.

DR. MAXWELL: How did practice change when it changed from safeguarding to vulnerable adults? What was the difference -- 15:01

A. The main thing was form filling. Before we were using the incident form -- and would that have been in a Datix? It was done in incident form, the forms. So they brought out -- then they introduced the staff to I think VA1 forms, which became an ASP form, which was changed again. But it was always immediate, it was always ring your, you know, notify your Nurse Manager immediate, your consultant, those people. But -- and then those forms were being, my understanding is going outside of the hospital to Social Services. 15:01 15:01

DR. MAXWELL: So before it was vulnerable adults who made the decision about whether to refer to a social worker?

A. Social workers were always involved, because they're always at your MDT every week, and they knew about all the incidences. 15:01

DR. MAXWELL: So you were recording the incident on an incident form, which as we know became Datix at a later date. 15:02

A. Yes. Yes.

DR. MAXWELL: Before it was an incident form. And these was always discussed at MDT?

A. Yeah. Absolutely.

DR. MAXWELL: Going back to 1999.

A. Oh, yes. Every multidisciplinary. And they were weekly.

DR. MAXWELL: So did the sort of things that should be recorded change? 15:02

A. Yes. We haven't talked about fear. Ever since after the Ennis Investigation the fear throughout that hospital --

DR. MAXWELL: Well before we get to that, did the policy about what should be recorded change? 15:02

A. The actual policy, yes, it did indeed, the safeguarding became a big policy then. I'm not sure what date.

DR. MAXWELL: But you as a nurse, having to decide what to put on the incident form, you would have a mental model in your mind about 'This is the sort of thing that needs reporting'. 15:02

A. Yes. Yes.

DR. MAXWELL: And an obvious thing might be a member of staff hitting a patient, but there are other forms of abuse; psychological, financial, whatever. 15:03

A. Yes.

DR. MAXWELL: Did the sort of things that should be reported, did you get more updates about 'Well, actually, this sort of thing isn't acceptable, you should report this'? 15:03

A. No. So you would have been filling a witness statement to the person then -- say it was told to you, then the person who seen whatever was meant to have happened, would have to detail that.

DR. MAXWELL: Yes.
A. That would be attached to the incident form.
DR. MAXWELL: But the -- but I'm trying to work out whether -- how it was decided something was abuse, because the witness form would come after somebody had filled -- had decided there was an incident, and so was that left to the discretion of individual nurses what made a safeguarding incident? 15:03
A. Well nurses, every nurse in charge on a shift would have training in safeguarding. 15:04
DR. MAXWELL: Right.
A. And would understand what to report. A whole list of all types of abuse was taught, you know, and that was on top of your.
DR. MAXWELL: Can you -- because my recollection as a nurse is we had a lot of training on child protection. 15:04
A. Oh, we had that too.
DR. MAXWELL: But we didn't get a lot of training on adult protection until some time later.
A. Oh, no, we did. It would have been I think three yearly for a while, and that would have been before this when the policy changed in 2011/'12. So we would have been attending -- it was called different -- it was maybe safeguarding training and then it was vulnerable adults. That's my memory of it. 15:04
DR. MAXWELL: Okay. Okay, if we can move on. So you've talked a couple of times, but particularly in paragraph 36, about primary nursing and for my colleagues can you explain what primary nursing is?

A. Well, practically I can. So, yes. So one nurse would be a named nurse, and as part of primary nursing then you focused only on maybe three or four patients. At one stage I had seven, eight, maximum. So you had a small group of patients and you had a few nurses who between you and them worked with that group. So your ward might have 40-something patients, 36, but there would be then maybe around five or six named nurses who were practicing primary nursing, so that was -- they were involved with that patient, or in a general hospital it would be that bay, you know, four or five patients. So you looked after their care holistically from the top to the bottom. So it might have been teeth, you know, dentist, it might have been just any surgery. Anything. So, you know. 15:05

DR. MAXWELL: So there was one nurse who knew each patient really really, well was monitoring everything about their care.

A. Yes. And the key workers then who were within that group, and they did. And away back, this is in the '90s, that was kind of -- so you were even allowed -- when Muckamore was considered more a home, you were developing that area for that person, you were buying whatever things they wanted to have around them. It was a lovely time to develop even skills for nurses as well as patients. 15:06

DR. MAXWELL: So would it be the primary nurse that was helping patients decide how to spend their money.

A. Well family, primary nurse, could be social worker,

could be -- yeah. Mhm-mhm.

DR. MAXWELL: Okay.

A. And they would have had a good --

CHAIRPERSON: On that topic, before Dr. Maxwell goes on, I understand that concept of primary nursing, but when you began to have staff shortages did that alter the effectiveness of primary nursing? 15:06

A. Oh, certainly it would have. By that stage when I began to feel that in the '12, I'm trying just to think of examples of primary nursing, the nurses would have been all over the place. They were just back to nearly, you're right, back to nearly looking after all groups and trying to share information and maintain the standards. I mean in both occasions of this horrendous ongoing investigation, and the Ennis one, the nurses like rose to the -- they really did deserve a lot of credit for holding that place together without patient error or injury that I am aware of, you know, because it was just -- you can't -- I couldn't write enough to help you understand the pressure. And that's experienced staff feeling that, those that were left. 15:07 15:07 15:07

CHAIRPERSON: But you need a stable staff, as it were, for primary nursing to work.

A. You do. Yes, you do.

CHAIRPERSON: Thank you. Back to Dr. Maxwell. 15:08

DR. MAXWELL: And just a final question from me. We talked a lot about staffing and how you raised concerns about staffing, but we didn't cover -- in paragraph 102 you said you couldn't take any more students, you told

corporate nursing, or the practice educator.

A. Mhm-mhm.

DR. MAXWELL: So not taking students is quite a big deal for the Trusts, they're in breach of their contract with the university. 15:08

A. Mhm-mhm.

DR. MAXWELL: So presumably that was quite a big deal. What was the response to you saying you couldn't take any more students at the moment?

A. From Queens? 15:08

DR. MAXWELL: From anybody?

A. Well, I mean even in my hopes and feeling at the time it was going to be temporary, do you know, it was going to be temporary. And then sure we never found out the answer because then. 15:08

DR. MAXWELL: So did you stop having students for a period?

A. Oh, yes. That particular week. We just hadn't enough to have a mentor for a student, and that was the real difficulty. There had been students right up until 15:09 that time, and they really, you know, had always positive experience about Ennis.

DR. MAXWELL: And the allocation of students is done by the corporate nursing team in the Trust?

A. Yes, it would be. 15:09

DR. MAXWELL: So the corporate nursing team would have known you were raising concerns about staffing?

A. Well if that was passed on -- that was very -- just before, it was like a few weeks before, again, the

allegations were raised, because I got word that one was coming, and it was obviously raising that there was no nurses, so that was going to -- that would be a good situation if it brought a student there at that time.

CHAIRPERSON: And I am so sorry, on that very topic, I just want to put a date on that, because we haven't got it in the transcript, but you refer in paragraph 102 to the 27th October 2012 in relation to not being able to take any more nursing students. 15:09

A. Yes, I'm sure that is that. Mhm-mhm. I have a wee e-mail about that. 15:09

CHAIRPERSON: Thank you.

DR. MAXWELL: That's my questions.

CHAIRPERSON: Okay. Professor Murphy. 15:10

QUESTIONED BY PROFESSOR MURPHY

PROFESSOR MURPHY: Yes, I just have one more question for you, which was; you say in your statement that you felt pressurised to move out of MAH and to work in the community? 15:10

A. Mhm-mhm.

PROFESSOR MURPHY: And I found myself wondering, given how stressful it was in MAH, why you didn't want to do that? 15:10

A. Because that's where I chose to work, and loved it. Loved it! Right until even I left and retired last year. You know, this all sounds so negative, but it's actually a nice environment to work in, and the staff

were good, you know. And at one time it was a very organised, well run environment and workplace. So why would I leave that? And I had -- sure I had applied years before that. And not only that, I was being put out of the hospital. That would be, you know, more humiliation. I've described that, you know, in my statement, you know. And I was receiving letters of redeployment, told I was going, and 'Would you like this place? Would you like the other?', and that was actually even before the report of Ennis came out. So before the report came out I was receiving letters, and I was beginning to learn how things work with HR, and I was beginning to ring them and ask them about their policies, and they would have explained that if you're getting offers of redeployment other people should be getting offers of redeployment. They might wish to leave even though you don't. You know, there was things like that. So I was realising that I was being singled out.

15:11

15:11

15:11

PROFESSOR MURPHY: You felt you were being targeted because --

15:12

A. Oh, I knew I was! It was an absolute -- I took a grievance out about that, and I was proven right about the redeployment -- mis-application and redeployment. So they -- well they accepted it and upheld it.

15:12

PROFESSOR MURPHY: Yes. So you wanted to stay because of your commitment to MAH, is that what you're saying?

A. Because of my commitment, sorry, what?

PROFESSOR MURPHY: To Muckamore.

A. That I stayed. Uh-huh. I absolutely adored it. Yeah. I probably would have liked other jobs too, but it was a very fulfilling career. Absolutely. And met lovely people, and that is the patients, the families, I know some of them now. You know, the nurses. Tremendous 15:12
support. It was just whenever things -- I never had problems with senior management or Trust executives, anything in my career, until the highlighting of the staff. And then, again -- and I wasn't popular from the first Ennis, because it was like, you know, I 15:13
probably made things difficult, you shouldn't say, speak against this Service Manager who was still there. People, colleagues would have said, 'that's why you're getting these offers', and they were seeing that too, you know. But I was adamant that things were done 15:13
well, as best as we could have, and that that was the reason that I was -- it was like if you -- because the tension was brought on to Ennis Ward that it was -- this was going to be another tick box, 'it was your fault'. And all along, you know, I've just went by 15:13
instinct, and I was actually glad when I left that it was the last one. It felt strange, but I actually took some sort of comfort in that I had got to the end. I did about eight roles after I declined taking the day sister's role, which is where incidents happen more, 15:14
and I was -- really did, and obviously other people did when that RCN representative said, you know, if you had another thing, and I thought 'well, rightly so'. So I know that this perception is part of this somewhere. I

would say it is a large part of it, but I don't know the facts.

PROFESSOR MURPHY: Thank you very much.

CHAIRPERSON: I think that's all the questions that the Panel have for you. But I do want to give you an opportunity, if you want to take it, to tell us anything else. 15:14

A. Yes. Well, I'm actually glad to have come along today. Thank you for giving me the opportunity, because I never felt I could speak to anyone about this, first of all. You know, the Trust send you out letters to say you're not to discuss this. My opinion of the media that it was almost 100% negative since this happened against Muckamore Abbey staff, what was the point, who was going to... 15:15

CHAIRPERSON: Sorry, just to stop you for a second. When you said the Trust send you out letters to say you're not to discuss this, referring to what?

A. You get letters if staff who go to McKinney House and if they, you know, they are told you may have seen something and then you're given supervision, and as a result of that, they then accompany that with a disciplinary policy. 15:15

CHAIRPERSON: Oh, I see.

A. So that hangs around in mid air until somebody addresses these things, which isn't happening. 15:15

CHAIRPERSON: Okay. Sorry, I interrupted you.

A. No, it's okay. Maybe -- just I suppose at that grievance that I mentioned, that was upheld on the

misapplication of redeployment, it was also -- much time was taken to say to the H507 Service Manager, about the absence of support to me, but that support was also, as we were discussing, about what was there for the staff. So it was acknowledged at that. 15:16

Also, that the staff in the Ennis situation accused, I understand where exonerated. Now one of them was a trained bank nurse who went between my ward and another ward, and she -- it was -- the charges were dropped early on. But the other lady who was a nursing assistant was completely exonerated but at appeal, and was back to work in Muckamore Abbey, and worked until her health couldn't take it anymore. And the other person was not a full-time member of staff there. 15:16 15:17

CHAIRPERSON: All right. I note in your last penultimate paragraph, paragraph 231. You obviously then wanted to talk more generally about nursing. Do you want to say anything about that?

A. Yes, thanks. I just want to read a wee quote, and this comes from the "Celebration Me" booklet or document, I'm not sure if you're aware of it, but it's learning disability, and it was a Chief Nursing Officer in England commissioned that. So if I could read this, because this is my experience of the nurses at Muckamore Abbey. So: 15:17 15:17

"Learning disability nurses are highly skilled, highly motivated, cost effective and highly valued

person-centred nurses. Wherever they work they have a proven track record of improving outcomes, reducing the impact of health inequalities and improving people's lives. They are unique, have enhanced communication and interpersonal skills, are important educators and can be part of the essential reasonable adjustments needed to reduce morbidity and unnecessary premature deaths of people who have learning disabilities."

So it was an engagement initiative and I read it and I just thought that is my experience of the learning disability nurses, and I just wanted -- I'm glad I got to include it. So, thank you.

CHAIRPERSON: All right. I want to thank you very much on behalf of the Inquiry for coming to give evidence. We do understand how stressful and difficult it can be to come and speak in public like this, and how much time you must have taken over your statement. So can I thank you very much for coming along to assist us. Your evidence has been helpful to the Inquiry, and I am now going to let you go. So, thank you. If you would like to go with the Secretary to the Inquiry.

A. Thank you.

CHAIRPERSON: Mr. McEvoy, what we'll do is we'll take a short break, and I think Ms. Briggs is going to deal with the next statement, so we will read the next statement, because we've got quite a full week and we want to get through as much as we can. But we'll take ten minutes now. Oh, yes, sorry, could everybody

remain in the room, I'm sorry, just for a few minutes so that the witness has the opportunity of departing discretely. Thank you. If people could remain on this floor and actually I'm afraid in this room just for a few minutes. Thank you. 15:20

SHORT ADJOURNMENT

THE HEARING RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS: 15:20

MS. BRIGGS: Good afternoon, Panel. Panel, this afternoon I'm going to be reading from the statement of H231. The reference is STM-226-1. And it's come up on the screens now. It's dated 9th April 2024. 15:39

CHAIRPERSON: Yes. Thank you.

STATEMENT OF H231 - REFERENCE STM-226-1 READ BY MS. BRIGGS AS FOLLOWS: 15:39

MS. BRIGGS:

"I, H231, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents to be produced with my statement. 15:39

My connection with MAH is that I am a full-time Band 8A Assistant Service Manager in Six Mile ward (Six Mile) in MAH. I began my employment with MAH in August 2018

as a Band 5 registered learning disability nurse. I remained in this role until September 2020 when I was promoted to Deputy Day Care Manager Band 6. In September 2021 I became a peripatetic Band 7 which meant I worked wherever staff were needed, however most of my time was spent on Six Mile. I am currently an Assistant Service Manager in Six Mile and have been in this role since March '2023 as a Band 8A. 15:40

The relevant time period that I can speak about is between August 2018 to the date of my statement. 15:40

I am passionate about caring for people. I hold a BA Honour's degree in Physical Education. As there was a lack of jobs available in physical education at the time I finished my degree, I considered moving into the care sector. I converted my degree to nursing. I attended Edinburgh Napier University and qualified as a registered learning disability nurse, Part 1 of register, in January 2018. I undertook a short employment as a learning disability nurse in NHS Tayside. 15:40 15:41

When I was employed as a nurse in NHS Tayside I worked at Strathmartine Hospital, Dundee. This was an in-patient low forensic unit. The unit comprised of both male and female patients. During my time there I witnessed an incident of abuse between a staff member and a patient. I reported the abuse and gave a 15:41

statement. I recall my colleagues did not believe that the person I reported could have done what I witnessed. After I reported the incident it became difficult for me to continue to work within NHS Tayside and I resigned. I took some time off work and decided that it was best for me to come home to my family who could support me. I left this position in August 2018 and began to look for job opportunities back home. 15:41

I was told by friends whose family members worked in MAH that there were recruitment opportunities within the Belfast Health and Social Care Trust (the Belfast Trust) with positions in MAH. My friends were connected to H359 and two others who are named. H359 worked in senior management and the other two were Band 5 nurses. They had no input or influence over my recruitment. My friends made me aware that the recruitment open day had been set up by the Belfast Trust. I attended the recruitment day that was held in Moyola Day Services Centre in MAH. I thought it was an open day where I would find out more information about the opportunities available, but interviews were held there on that day. I was not prepared for interview and was concerned that I would not be successful in my application. As I had flown from Scotland to Belfast that morning to attend the open day, I was given another opportunity by the Belfast Trust to attend an interview. I was successful and offered a Band 5 registered learning disability nurse role. I do not 15:42 15:42 15:42

recall who interviewed me.

Prior to my official start date in MAH. I attended a corporate induction. However, the induction did not take place and I was sent to Six Mile Ward to meet the team as this was the ward I was to work on. I met with H261, a Band 5 nurse, who introduced me to staff and patients on the ward. Six Mile is a male only ward where patients have a forensic history. As it was meant to be an induction day I was not required to wear my uniform. It was assessed by H261 that as I was wearing jeans, a hoodie and a top, it was not appropriate for me to be on the treatment part of the ward as there was a risk I may dysregulate patients. I remained on the assessment ward. I witnessed one incident on that day where a patient was aggressive towards staff. The patient was called P140. He received his medication which was placed in a cup and given to him the same time each day. His medication was delayed which caused him to become very aggressive as did he not like that it was not available. As P140 was distressed, he tried to cause harm to himself and others. I was very impressed with how staff worked together to calm him. The staff understood that he was frustrated that his medication was not available so they took a calm approach with him. They placed P140 in MAPA hold so that he could not cause harm whilst the nurse gave him the medicine which calmed him. I was told by H261 that an incident involving a patient

15:43
15:43
15:43
15:44
15:44

occurred on the treatment side that day, but I do not know the details.

I undertook training in Scotland which was equivalent to MAPA, but I was required to carry out further training by MAH as the training I received in Scotland was deemed to not be in line with Belfast Trust requirements. All mandatory training in accordance with the matrix comprised by the Belfast Trust, to include adult safeguarding and manual training, was provided. I attended MAPA training over five days in Portmore. Due to the shortage of staff in 2019 there were times when I was scheduled to attend training but I could not. In these instances training was rescheduled and attended. I attend compulsory training courses as required. 15:44 15:45 15:45

I started my full-time permanent position as a Band 5 registered learning disability nurse in August 2018. Every morning my shift started at 7:30am. I reported to the treatment side of the ward and was allocated roles in either treatment or assessment. The areas in which I was allocated to work was set by the previous shift nurse in charge and the morning nurse in charge allocated the roles. At this time H13 was the charge nurse. H14 who was a Band 7 forensic practitioner, provided psychiatric support to the young men on the ward. I received a warm reception from staff in Six Mile. Patients on Six Mile sometimes displayed 15:45 15:45

behaviours of a sexual nature, so, as a young female, the nurse in charge ensured that when I began my shift they provided a detailed handover and a picture portrait setting out the needs and level of supervision required by the patient. 15:46

When I first started working on Six Mile there were 14 patients. There are now nine patients on the ward. There is a high level of risk in caring for patients on this ward because of their challenging behaviours. 15:46 Most patients can verbalise their struggles and when they're unhappy or their needs are not being met, for example, when they want a drink or they were unhappy about another patient's presentation. The patients had a good rapport with staff. Patients at times could 15:46 have stated that they did not like a staff member, but this would usually have been due to safety or risk management. For example, a Department of Justice approved risk assessment is very specific in how it is outlined and which areas patients can access. If a 15:47 patient tried to deviate from this and the staff advised them that this could not take place, the patient may have verbalised their unhappiness with this.

15:47

Working with patients on Six Mile involves a risk of being assaulted. Patient-on-patient and patient-on-staff assaults occur regularly. There was a patient named P54 who was highly sexually preoccupied.

P54 had carried out sexual assaults on both male and female members of staff. There were times when P54 was placed in seclusion as a last resort. In November 2018, I, along with two nurses, were sexually assaulted by P54." 15:47

And the next part, Panel, is subject to R063.

"I reported the incident to my manager H220 and I took three weeks off work as a result of the incident. 15:48
Where staff were assaulted, it is hospital policy that it is the individual staff member's decision to report any incidents to the Police Service of Northern Ireland (PSNI). I reported the assault to the PSNI and the matter was referred to the Public Prosecution Service 15:48
who decided not to prosecution as they felt P54 did not have the mental capacity to understand the court process and it was not in the public interest to prosecute. It was a very difficult and challenging time. I fully understood that this individual was 15:48
unwell, however, this was still something which I felt very violated by and took a long time to repair.

When I returned to Six Mile after the incident, there were many agency staff working on the ward. P54 was 15:48
displaying inappropriate behaviours towards agency colleagues with verbal and physical abuse. When I spoke with agency staff they told me that they were used to behaviours like this from patients and they

tolerated them. At that time there was a lot of tolerance on the ward in respect to P54 and his behaviours, as it was accepted that he could not control his behaviours. He often punched people with force to the head. It was very difficult to predict when P54 would become triggered as there were no signs. There was little support within MAH so I got external support from a counsellor and was directed to staff services. It has now changed in terms of how staff are supported. H234, who is a co-director of MAH; H702 and H631, who are both Band 8B on-site service managers in MAH, are particularly focused on looking after staff's mental health as they come from a mental health background. All three are approachable and take on board what staff have to say. They are able to take a view on how working practices are on the ward and consider steps that can be taken to support staff on the ward. 15:49 15:49 15:50

During my shifts I worked with at least three or four Band 3 care assistants. Each morning the charge nurse provided me with a handover sheet that listed the names of staff on shift. I allocated job roles to Band 2 and Band 3 staff, to include attending to patients' personal hygiene, taking patients to breakfast and carrying out cutlery checks. Care assistants were often required to stay with a patient on a prescribed level, which is based on the needs of the patient. When a care assistant returned from bringing a patient 15:50 15:50

to day care I asked them to provide an update on handover.

I was supervised by Band 6 nurses. I met with my Band 6 deputies, H226 and H220, twice a year to discuss any clinical development concerns that I had around my role, shift patterns and welfare, and future planning. Even though a formal meeting was held twice a year, if I had any issues I wanted to discuss, I could do so with them at any time, I could have linked in with H220 and H226 at any point. 15:51 15:51

As a Band 5 nurse, I was aligned with a named patient. I assessed the patient's daily living activities to include day care needs, any new medication that had been prescribed, and review the patient's care plan. Each care plan was based on the patient's individual needs. Where a patient became more dysregulated than usual, I considered if they required mental health support or physical support. I uploaded this information to the PARIS system. A Band 6 or Band 7 nurse carried out audits of patient care plans uploaded to PARIS. Relevant information from the patient notes on PARIS were relayed to the multidisciplinary team during the ward rounds by the ward manager. 15:51 15:51 15:52

Many staff in Six Mile had worked with patients for many years and were seen as family who looked after them. After the allegations of abuse were made, some

long-term staff were suspended on a precautionary basis in December 2018. By January 2019, the number of Trust staff in Six Mile depleted as H14, H873, H874 and H875, H876, (Band 3), H877 (Band 3), H878 (Band 3), were placed on cautionary suspension. There were days when 15:52
a member of staff would start their shift and leave the ward mid shift without returning. At this time there was limited communication from senior management, so I did not know what was going on, but found that some shifts were now short staffed without notice. This 15:53
increased the demand and pressures on remaining staff. Staff would have been met by a senior manager at the beginning of their shift to advise that they had to leave site. The senior manager would have advised the nurse in charge that they would not be on duty. Staff 15:53
support from other wards would have been sought to backfill, however on many occasions there was no cover provided.

Although I was relatively junior on the ward and not 15:53
yet a year qualified, I had suddenly moved up the roster, taking on the role of nurse in charge. In this role I ensured all allocated tasks were carried out, ensured paperwork was completed, and escalated issues to management if required during that shift. It was 15:53
difficult to replace the staff that had been suspended as staff within the other Trusts did not want to work in MAH because of the reports about abuse. Due to staff shortages, agency staff were brought in during

summer 2018. This was a difficult time for patients and staff. I worked on Six Mile for five months by the time staff began to be placed on precautionary suspension and during this time I did not see anything untoward. If I did, I would have reported any incidents. 15:54

When the Psychiatric Intensive Care Unit (PICU) closed, patients were moved to other wards. PICU was for patients who required urgent assessment and treatment. 15:54
P18 was the only patient from PICU who was moved to Six Mile. Although P18 does not have a forensic background, he is deemed high risk with challenging behaviours, so it was assessed by senior management that Six Mile was the best ward to meet his needs. 15:54
P18 had a diagnosis of autism and found the change to his routine very challenging. To support him a Band 5 health care assistant moved across from PICU with him.

Patient-on-patient incidence and assaults on staff occur regularly on Six Mile. If a patient is dysregulated this could happen on a daily basis, sometimes multiple times within a day. MAPA restraint is used when required by trained staff. There were times when patients would become upset if another was getting more support from staff. Staff tried to de-escalate behaviours by using calming techniques. MAPA was used where other techniques did not de-escalate behaviours." 15:55 15:55

The witness in the remainder of that paragraph goes on to describe the particular behaviours of Patient P140 and how that was managed by the use of MAPA in particular. 15:55

Picking up at paragraph 18, half way down page 8:

"When PRN was to be administered it was only done following consultation between at least two nurses. 15:56
PRN can be administered as analgesia, for example, where a patient is suffering from toothache or is constipated. PRN sedation may be administered for agitation and has a sedative effect on the patient.
Where a patient is displaying self-injurious actions 15:56
and MAPA restraint is required, PRN sedation may be administered to the patient to return them to their baseline. Staff would utilise positive behaviour support (PBS) plans and formulations, and ultimately have a good knowledge of the patient to understand when 15:56
they had returned back to their normal pattern of presentation. Where PRN is administered it is recorded on the patient's records along with an explanation for why it was used.
15:56

Six Mile did not have a seclusion room, but there was a bedroom called Room 7 that was used for seclusion when needed. The room was not allocated to a patient.
Where a nurse on the ward considered seclusion may

benefit a patient, as per hospital policy, the patient was assessed by the dedicated MAH consultant psychiatrist, Dr. H50. If Dr. H50 was not available, an out-of-hours consultant, who was often off site, attended the ward to carry out an assessment on the patient within one hour of contact. There were occasions when the out-of-hours consultant did not attend within the hour as under the policy. Where the this occurred, it was escalated through Datix. Through this reporting system the reason why the out-of-hours consultant did not attend would be looked into with the reason most often being due to pressures as the same consultant would often be at Beechcroft Child and Adolescent Mental Health Unit on the Saintfield Road in Belfast. There was a rota schedule of consultants. 15:57 15:57 15:57

When a patient was placed into seclusion in Room 7, staff who were usually Band 3, stood outside the room at all times and monitored the patient. The staff member who was observing the patient would record information on the patient's presentation during the seclusion period. The information gathered was added to the patient's records on PARIS and added to their seclusion care plan. As I was a Band 5 employee, I had access to the PARIS system. Band 3 staff also had access, however, my practice was that I would transcribe the notes taken by the staff member on to PARIS and update the patient's seclusion care plan." 15:58 15:58

At the next paragraph which, is paragraph 21, the witness describes a particular Patient P60 who used seclusion regularly, and that was at the patient's own request, and the witness goes on to describe P60's particular behavioural needs. 15:58

Turning to paragraph 22, towards the top of page 10:

"There were times when another patient P18 was moved from PICU to seclusion in Room 7. When P18 became 15:59
aggressive, alternative calming techniques like engaging him in activity often did not work, so there was a need to use MAPA restraint. Staff cared for P18 and all other patients in accordance with the clinical practice guidance on restrictive practice issued by the 15:59
National Institute for Health and Care Excellence, (NICE). There were times when P18 needed to be restrained for long periods before he became settled. P18 is tall and weighs approximately 22 stone, so restraint was difficult for P18 and difficult for 15:59
staff. When nursing staff assessed that seclusion would help P18, in my experience and to the best of my knowledge they followed the protocol of contacting a consultant psychiatrist for assessment. 15:59

I recall an incident occurred on 26th December 2018, when P18 was in Room 7. The room had a bed and a window with perspex glass. P18 became dysregulated and kicked the perspex glass. The window broke but did not

fall on to or injure P18 as there was a film over it. Following an inspection by RQIA they found that the perspex was not suitably reinforced and Room 7 was not suitable for use as a seclusion room.

16:00

After the RQIA inspection, it was decided by senior staff on the ward that as PICU was the only ward with a purpose built seclusion room, and was very close to Six Mile, it was to be used when needed. A patient was only to be transferred to the seclusion room on PICU if 16:00
they were able to walk. Where a patient was not able to walk to the room the PSNI would be asked to attend to bring them. For example, when P18 became distressed, he would sometimes destroy property and use it as a weapon on staff. If he was placed in a MAPA 16:01
restraint and continued to display aggressive behaviours, nurses assessed if seclusion would help him to become settled. There were occasions when the PSNI were called to transfer P18 across to the seclusion room in PICU as he could not walk. Staff remained 16:01
outside the door during these times.

On observing P18 I identified that his behaviours escalated when he was bored, due to lack of activity. I spoke with behavioural support and day services to 16:01
put a plan in place to support P18. This was led by what P18 wanted. He expressed that he wanted his plan to include increased activity with the support of day services and for this to be incorporated around his

home leave. P18 now has activity on a daily basis. He is not always willing to engage, but the session is available. Activities include community outings and day care sessions, such as cooking and aromatherapy.

16:02

In relation to families of patients, I was in regular contact with families and carers. When an incident occurred, I contacted the patient's family or carer to tell them what happened and, for instance, if PRN had been administered. Some families contacted the ward on a daily basis, so there were times when I updated them when they called.

16:02

I was promoted to the position of Band 6 Deputy Manager in September 2020 and I remained in this role until September 2021. I was placed in Moyola Day care. In day care I did not administer medication and did not have access to any patient medication. PRN sedation and seclusion were not used. As elsewhere, MAPA restraint was used when other de-escalation techniques did not help the patient. There were occasions when patients were unable to stay at day care as their behaviours had escalated, so they were brought back to the ward by care staff.

16:02

16:03

My role as a Band 6 Deputy Manager in Moyola was very different to that of Band 6 nurses on the wards. My role focused on improving day services and reviewing plans for patients across all wards in MAH. I managed

a team of Band 3 care assistants and Band 5 social care staff. I was responsible for allocating their daily tasks and schedules. This included taking patients to the on-site swimming pool. I attended multidisciplinary team meetings and met with patients on each ward to find out what they needed and how to improve their daily routine. I looked at the patient's timetable each day and recommended suitable activities to fill any gaps. For example, shopping trips for the patient. 16:03

I worked with Allied Health Professionals and psychologists to identify and consider patient needs when arranging events. A Christmas party was held in the day centre, so in advance we discussed the sensory and dietary needs of the patients. Families and carers were invited to the party. I reached out to external providers to arrange events, such as street soccer, to help integrate patients into the community. As part of this, I, along with Band 5 staff, would take patients off site for day trips. There was a patient on Cranfield 2 who was autistic, non-verbal and does not like people to be within his environment. He has a photographic memory, which increased the risk of him running away from his carers to get home. After working with him to help de-sensitise him we were able to take him to the beach with his family. This would not have been possible without the support offered to him through day care. 16:04 16:04

I had access to patient care plans. If a patient's presentation changed then would I consider this when scheduling their day. If an individual was subject to a Department of Justice restriction where they were not permitted to leave the MAH site, I updated their care plan and made day care staff aware of the change. 16:05

I remained in my role as a Band 6 ward manager until September 2021, at which time I commenced a Band 7 ward manager role on a peripatetic basis. I had met the eligibility criteria and was successful at interview. Although I could have worked on any ward in MAH, a need for a ward manager was identified on Six Mile. The Ward Sister's role was changed to non-clinical which meant that she had no contact with patients. 16:05

As a ward manager on Six Mile, my role was to be supernumerary with an oversight of staff working on the ward. As there were staff shortages I often took on staff roles to help ease the pressures. I was the nurse in charge and allocated roles and tasks to staff. I oversaw their daily tasks to include ensuring medication was administered in accordance with patient need, recording of patient notes, and supporting staff with levels of patient observation. I ensured staff took their breaks to help manage stress. I helped engage patients in activities. I also observed patients to find out if they were happy and content or 16:05 16:06

if there was a change to their presentation that required support.

I worked collaboratively with allied health professionals to include speech and language therapists and occupational therapist. As part of observing a patient I recorded any changes in their presentation. If there was a change in the way a patient swallows or if they choked, I arranged for a speech and language therapist to assess the patient and update their safeguarding and protection plans. When a therapist prepares an eating plan for a patient, I ensure that the changes are displayed in the observatory of the kitchen so that the PCOS (Patient Client Support Services) who prepare the meals, could see it. I also updated day care on such changes. 16:06 16:06 16:07

I reviewed care plans and nursing records on a weekly basis. A live governance structure carried out audits on the plans and records. I provided my weekly review update to H230, Band 8 approved social worker, who reported to H300 Service Manager and H882, divisional nurse with the Belfast Trust. I understand they regularly met with the governance lead or clinical director to discuss any incidents recorded, PRN administered, and seclusion relating to each patient. A change in the management structure occurred in August 2022 when two Service Manager roles were created. There was previously only one. H631 and H702 are now 16:07 16:07

both service managers. They provide to me any feedback that senior management has following ward rounds and I inform nurses on Six Mile.

Datix is an incident reporting system. Any person who holds a managerial position can review Datix forms. I review patient-on-patient incidents. Datix records all incidents and produces a graph showing how many times patients have been involved in incidents, which helps me identified any patterns in behaviour. 16:08

In my opinion staff have sufficient CPD opportunities. As a Band 7 ward manager I supervised Band 6 nurses who in turn supervise Band 5 nurses. Where training needs or the need to upskill is identified, this is arranged. 16:08 I received support in my daily role from H230, H882 and H300.

I began my role as a Band 8A assistant Service Manager in March 2023. I report to the divisional nurse..." 16:09

-- who is named.

"I directly report to H702 and H631. My duties include setting rotas for staff. Since December 2018, it has 16:09 been very difficult to retain Trust staff. I believe a combination of the media coverage of the allegations of abuse, the perceived high levels of aggression expressed by some patients, and the risk of assaults,

including sexual assault, contributes to these difficulties. As a result, an increasing number of agency staff work on the ward."

The witness goes on in that paragraph to describe how bank or agency staff are brought into the ward when needed. 16:09

Paragraph 38 at the bottom of the page:

16:09

"Although my job title and role has changed, the working environment has not. As Six Mile is a forensic ward, patients continue to exhibit aggressive behaviours to staff, patients, and at times their family members. Recently a patient, P54, was violent towards his mother. The patient struggles to understand time, so staff do not say to him something will happen at a particular time in case it does not and then upsets him. I understand with this incident there was a discussion around trousers not arriving on time, which seemed to have triggered a reaction in the patient. After the incident with his mother, she and the family did not visit him, as she understandably felt she needed some time. The patient has fears of abandonment and when his family did not visit he became increasingly aggressive and when he was stressed he would vomit. When the family began to visit him again they noticed a change in him. They were not happy with his presentation. We explained how the patient had

16:09

16:10

16:10

been when they took a break, but the family thought that there was another reason for his stress. To help reassure the family we were referred their concerns to the Senior House Officer in MAH who referred the patient to a consultant for review in Antrim Area Hospital. The patient was diagnosed with a urinary tract infection, but found nothing to suggest he was unwell. The family asked for a second opinion, so I arranged for the family to meet with senior management and a consultant to discuss their concerns. This is just one example of the processes and safeguards in place when families raise concerns. 16:11 16:11

Where a family or a patient make a complaint against staff, a senior member of staff completes an APP1 Form, a Form 2 is also submitted to RQIA, this is not normal practice within hospitals but is required for MAH. The safeguarding team within the Belfast Trust review the complaint and provide feedback to H702 or H631, who put a plan in place to try to protect the safety of the patient and staff. 16:11 16:11

As previously explained, a high level of patient-on-staff sexual assaults occur on the assessment side of Six Mile. Support for staff has improved since I joined. All incidents are reported on Datix and are formally reviewed. Staff are directed to the counsellor for MAH and can self refer if they require support. Human Resources work with staff who 16:12

are absent due to sickness to assess if it is in their best interest to return to work or not. In an effort to mitigate risks to staff, where possible, only male staff work on the assessment side of the ward which the patients in general seem to like. 16:12

Reasonable adjustments to mitigate the risk of patient-on-patient incidents have been made, often these incidents arise because patients to not want to live together. For example, P54 has his own space in 16:12 an annex which helps him. I have put plans in place to ensure that patients who upset each other eat at different times and areas. I, along with my team, try to provide the best environment for patients until they are resettled. 16:13

A weekly live governance report is provided to the divisional nurse. All incidents are included in the report. H807 of corporate governance reviews any incidents and advises if they meet the threshold to be 16:13 deemed a significant incident and, if so, provides details of the steps to be taken.

Although I work in a challenging environment, the culture and practices on the ward are good. As a 16:13 manager I ensure safe and effective practice to meet RQIA standards. I do my utmost to ensure that staff treat each other and patients with respect. I have a good relationship with adult safeguarding which means

if a patient makes a complaint or staff notice, for example, unexplained bruising, all concerns are referred to the team. There is a dedicated adult safeguarding team for MAH. RQIA carry out up to two inspections a year, one is announced and one is unannounced. RQIA has the power to review Datix, PARIS, rotas, and assess the ward generally. Where feedback is provided by RQIA, I, along with another Band 8A nurse, create an action plan to comply with any recommendations made by RQIA. 16:14

The Chief Executive of Belfast Trust and the Executive Director of Nursing often visit Six Mile to speak to patients and staff about practices and how things are generally, to ensure a safe and effective service is provided. I understand they feed back to the Executive Team within the Belfast Trust. 16:14

As a Band 7, and now a Band 8A, I carry out audits on patient's finance and property. I check each patient's ledger to ensure the figures balance. The finance officer in MAH conducts monthly audits on two randomly selected patient ledgers. There are times when family come to visit and give staff money when they are there. When accepting the money, staff offer families a carbon copy of a handwritten receipt. Families do not always take a receipt, but it is offered to them. Some families have requested that ledgers are sent to them each week. Where they raise any queries I ask the 16:14 16:15

finance officer to carry out a review of the ledger and money held. Recently a family member thought that the ledger for her son, she was the next of kin, was £50 short as it showed £50 coming into the account and then out. The payment of £50 was from the Belfast Trust Charitable Funds Scheme to buy patients a Christmas present. We sent her a copy of the ledger and receipts for expenditure. The finance officer carried out an audit and the query were resolved. Where patients own higher value items like mobile phones or jewellery, these are listed, and checks are done to make sure the property belonging to the patient matches what is listed. 16:15 16:16

I have been involved in patient discharges since I began working in MAH as a Band 5 and continue to do so. I provide information to assist the multidisciplinary team with assessing patient need and link in with a supported living provider. As a Band 8A, I arrange In-reach and Out-reach, which means that the provider can come onto the ward to learn about the patient's care plan, or a member of staff goes to the provider to help them set up for the patient's arrival. I attend ward rounds to discuss progress on resettling the remaining patients on the ward. 16:16 16:16

I cannot fault the support given to my team. My day-to-day working team is comprised of one Band 7, two Band 6 and Band 5 staff. As a manager my aim is to

provide patients with the best life they can have on the ward. I am available to speak to family members when they call, but obviously I cannot always be available. I asked senior management to create Expression of Interest (EOI) positions that would allow other members of my team to speak to families to ensure that families can talk to someone immediately if I am not available. This was approved. I have arranged cinema nights for patients and senior management has approved any request for funds to bring in projectors and associated costs.

I believe the work of the Muckamore Inquiry to be extremely important and that any lessons that should be learned are learned. I have found the statement making process to be extremely challenging."

The witness goes on in that paragraph to make some observations about that for the attention of the Panel.

16:17

16:17

16:17

CHAIRPERSON: Yeah. And I've actually made a statement earlier this week in relation to why I felt it necessary for witnesses to make statements to an independent firm of solicitors. All right.

MS. BRIGGS: There is one more paragraph, Chair.

CHAIRPERSON: Yeah. 49?

16:17

16:18

MS. BRIGGS: 49. I'll pick up there:

"Since the allegations of abuse came out and the Public Inquiry started, there have been times when I have

taken patients out to Antrim town and members of the public have made derogatory comments to me about working in MAH. I am proud to work in MAH and with the patients on Six Mile. My aim is to provide patients with the best care and support possible until they are resettled in the community and I will continue do this to the best of my ability." 16:18

The witness then signs and dates the statement.

CHAIRPERSON: Okay, Ms. Briggs. Thank you very much indeed. 16:18

In relation to last week's transcript, last Wednesday, and in relation to the evidence I think it was of H260, at page 54 of the transcript line 8, there was apparently an error. It wasn't the transcriber, it was counsel. For MAH staff members H578 and H788, it should have read H78 and H778. We will get that corrected. 16:18

INQUIRY SECRETARY: Did you say H471? 16:19

CHAIRPERSON: Was it H471? Ah, sorry, my fault. Thank you. In any event, we can get that transcript now corrected and put up.

Tomorrow, I'm going to make a short statement in relation to criticisms of staff by other staff and how the Inquiry is dealing with those. Otherwise we are sitting tomorrow at 10:00 o'clock. Okay. Thank you everybody. See you at 10:00 tomorrow. 16:20

THE INQUIRY ADJOURNED UNTIL TUESDAY, 14TH MAY 2024 AT 10.00AM.