MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 4TH JUNE 2024 - DAY 87

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THE INQUIRY RESUMED ON TUESDAY 04TH JUNE 2024 AS FOLLOWS:

CHAIRPERSON: Thank you. Yes. Mr. McEvoy.

MR. McEVOY: Morning Chair, morning Panel. The evidence this morning will be heard from Eilish Steele. 09:52
There is an application, Chair, for a Restriction Order.

CHAIRPERSON: Yep.

MR. McEVOY: If that could be made in the usual way.

CHAIRPERSON: Yep. So I'll make a Restriction Order 09:53
over this application so that if I do make the order, it has an effect.

(RESTRICTED SESSION)

(OPEN SESSION RESUMED) 09:53

MR. McEVOY: Chair, before this witness is brought in, could I --

CHAIRPERSON: Could we open up to Room B again first?

MR. McEVOY: Sorry, Chair. 09:56

Thank you, Chair. Before this witness is brought in, I just want to take the Inquiry back to yesterday's proceedings momentarily. It will be recalled that during the evidence of H324 yesterday, she was asked to 09:57
confirm whether or not she knew the full identity, full name of the patient under the cipher 227.

CHAIRPERSON: And she wrote it down for us.

MR. McEVOY: She wrote it down, and we are able to

confirm that, in fact, that patient is P1.

CHAIRPERSON: P1, thank you. All right. Right.

MR. McEVOY: I think we can bring the witness in now.

CHAIRPERSON: Just lost the secretary to the Inquiry.

MR. McEVOY: One step ahead of me as usual. 09:58

CHAIRPERSON: And there's no cipher involved with this witness, is there?

MR. McEVOY: No.

EILISH STEELE, HAVING BEEN SWORN, WAS EXAMINED BY MR. MCEVOY AS FOLLOWS: 09:58

CHAIRPERSON: Ms. Steele, can I just welcome you to the Inquiry. Thank you for your extensive statement, which reaches back to when you were a student, and thank you 09:58 for coming along to assist the Inquiry. Obviously we are not going to be hearing the whole of this statement but Mr. McEvoy is going to alight on those parts which he thinks is most going to assist the Panel. I'll hand you over to him. If you need a break at any stage, we 09:58 normally take a break after an hour but if you need a break earlier than that, or at any other point, just let me know.

A. Okay. Thank you.

1 Q. MR. McEVOY: Good morning, Mrs. Steele. Before you is 09:59 a folder, it contains your statement to the Inquiry. The statement is about 101 pages in length. Are you content to confirm that statement as your evidence to the Inquiry today?

A. Yes.

2 Q. I do understand, however, that there are a small number of changes that you'd like to make to the content of the statement?

A. That's right, yes. 09:59

3 Q. They are fairly modest in nature. Can I take you first of all to paragraph 143.

A. Yes. The sentence that says "The policy in relation to seclusion was that..."; if we could take the rest of that sentence out and say that changes to "The nurse in 09:59 charge was responsible for notifying" --

4 Q. Nice and slowly. I am sorry, I should have reminded you, Mrs. Steele, at the start, if we can try and keep our voices up and also speak slowly.

A. Okay. 10:00

CHAIRPERSON: "The nurse in charge".

A. "The nurse in charge was responsible for notifying the duty medical officer and the duty nurse, Senior Nurse Manager, to authorise seclusion."

CHAIRPERSON: Hold on. Thank you. 10:00

5 Q. MR. McEVOY: Okay. Then, Mrs. Steele, overleaf at page 38, I think it's paragraph 149 - it might be over to the top of page 39 - was there something you wanted to --

CHAIRPERSON: Can you hold on one second, Mr. McEvoy, 10:00 I'm still writing.

MR. McEVOY: Sorry, Chair.

CHAIRPERSON: Yep.

A. Yes. At the top of that page where it says "It was

impossible to release portions of funding", if I could change that to "It was impossible to release full funding for professionals who had hospital and community responsibility for all the Trusts."

CHAIRPERSON: Right.

A. Sorry, could I add, "Negotiation on bridging funding was necessary led by the hospital business manager, Oscar Donnelly."

CHAIRPERSON: Okay.

6 Q. MR. McEVOY: Turning to page 49, this is within paragraph 182, looking down towards the bottom of that page, there is a sub-paragraph N. Was there something that you wanted to say about that paragraph?

A. Yes. I would just take that whole paragraph out; it's out of place.

7 Q. The whole of paragraph N?

A. Yes, please.

8 Q. Then finally, as I understand it, looking across to page 65 and to paragraph 235(a).

A. Yeah.

9 Q. Was there something you wanted to say about that sub-paragraph?

A. Yes, please. The last sentence, take out "packaging and dog food". So it's "Dog biscuits, which was part of a contract programme within day care."

CHAIRPERSON: So you want to insert "dog biscuits which was part of a contract programme within day care"?

A. Yes.

CHAIRPERSON: All right. Sorry, I just want to

understand that. You're talking about Prader-Willis syndrome, and you say "These included taking food from other patients and eating unsuitable things such as dog biscuits."

A. Yes. As part of the day care programme, they had a contract for packaging dog biscuits. 10:04

DR. MAXWELL: So they were employed, packaging dog biscuits?

A. Yes.

PROFESSOR MURPHY: That's explaining where they came from, yes. 10:04

CHAIRPERSON: I see.

DR. MAXWELL: They weren't feeding them dog biscuits in day care.

A. No. Sorry. 10:04

CHAIRPERSON: That's a relief, anyway. I just didn't understand where that was going. I'm glad I asked. Okay. Right, is there anything else, Mr. McEvoy?

10 Q. MR. McEVOY: I think that's all of the amendments you wanted to make? 10:05

A. Yes.

11 Q. With those in mind, you're content to confirm the statement?

A. I am, yes.

12 Q. Thank you. As the Chair has indicated, Mrs. Steele, you've had a very extensive career in Muckamore and indeed, as you tell us in your statement, it goes back to 1974 and goes right through until 2011? 10:05

A. Yeah.

13 Q. In the first third approximately of your statement, you have focused on the period really up until about the late 1990s, which is prior to the period which is the focus of the Inquiry's interest and its Terms of Reference. But there are some matters, if I can touch on them, that you have covered in the course of those paragraphs, and if I could just ask you about those, first of all. 10:05

Thinking back, and it is quite some time ago, thinking back to what you say at paragraph 6, you have mentioned back in your student days being based, in paragraph 6, at Muckamore School of Nursing? 10:06

A. Mhm-mhm.

14 Q. Can you tell us a bit more about what the School of Nursing was? 10:06

A. Yes. The School of Nursing was still part of the main central school for Mental Health and Learning Disability Nursing, which was based at the then Purdysburn site in Belfast. After you completed 18 months, where during the first 18 months we had placements in mental health, general nursing and learning disability, and say there was 90 something students at that stage and everybody completed their enrolment registration part. Following on then, some people - and there were 12 of us - then went to register as staff nurses, registered nurses in the learning disability section. 10:06 10:07

15 Q. Yes.

A. And there was a college of nursing, school of nursing within the grounds at Muckamore. That was where we were based, that was where our main tutors were, and the library was and the facilities were. We went out from there on placements but we were still part of the overall big school, and returned there for some general modules.

16 Q. That's helpful. I don't think the Inquiry has heard very much about that from a witness. That's been useful. 10:07

CHAIRPERSON: How long? When did that end, do you know?

A. Whenever it became... I can't recall the date but --

DR. MAXWELL: 2000.

A. Pardon? 10:07

DR. MAXWELL: When it became Project 2000.

A. It became Project 2000, yes. Yes.

CHAIRPERSON: Is that right? We had better have the evidence from you. It is Project 2000.

A. Project 2000, yeah, and it became Project 2000. 10:08 Pardon.

DR. MAXWELL: No. It started before 2000; it was just called Project 2000.

CHAIRPERSON: Okay. Thank you.

17 Q. MR. McEVOY: Moving forward, if I can take you through 10:08 to page 7 and to paragraph 24. Again, you're thinking back to your early days in this paragraph, and you tell us that the hospital was very large in the early days and housed around 900 patients.

"There were separate male, female and children's units. The policies and practices were overall the same for all parts of Muckamore, and remained the same from the early days in my career as in the later years. However, there were subtle differences in working practice. For example, the male wards in Muckamore were run by Mr Hill, while the female and children's wards were run by Matron Mrs Duncan. This was a historic thing and not during my time at Muckamore, while there were changes and responsibility for the entire Muckamore Abbey Hospital became Mrs Duncan's role upon Mr Hill's retirement in the late 1960s." 10:08 10:09

Then you go on to say: 10:09

"For example, after this, we persisted in referring to the male side and female side of Muckamore Abbey Hospital, even though this didn't really exist. I only worked on the female side of Muckamore but I think there were differences. There was an amalgamation of these in the late 1980s." 10:09

Can you explain for us a bit more about this split between the male and female sides working differently, and how -- and if it did, how that culture persisted into the latter part of your career? 10:09

A. Yep. Historically, if you were working on the male side or the female side, whichever one, staff just

alternated in that side, you know, between the male wards and the female wards. There was very little crossover of staff moving across wards to cover, either to transfer as a permanent post or, say, to go out on a relief basis. The nursing officers, senior nurse managers for the male side and the female side worked their own wards, managed their own wards. There was little change or crossover.

The other thing would have been like the duty, thing around the duty rota where the male side maybe had -- you know, you had your two days off, alternating the same for the next week. There wasn't the same flexibility maybe in the rota, which impacted maybe on particularly female nurses with children and responsibilities didn't particularly like the style of the rota on the male side. It was known as the male and the female side up until it all amalgamated then in the 80s and worked more where people did crossover. We saw then reduction, for instance, of female, more female students going to work on the male wards.

DR. MAXWELL: Was there a difference in the practice of nursing on the male side?

A. I don't think there was significant. I'd only worked, I think, on one male ward during my student nurse training. The policies, the overall policies, were the same, and the patients went to day care and had the same opportunities for recreation. So the overall male, the thing wasn't really much different.

DR. MAXWELL: Do you think an all male environment was more likely to lead to some sort of conflict between patients or between staff and patients, or did you not see that?

A. I don't think -- I don't particularly think so. I think probably the female reduction of -- sorry, the introduction of female staff brought more of a, there was probably more of a social outlet, sort of a more concentration on personal items and personalisation of items for the patients. 10:12

The one ward that I could comment on would be - and it would be later in my career when I took over as a senior nurse manager - would have been the difference between the male and female semi-secure units, where I found in the male ward much more of the legacy style of Mister, you know, Mr. So and So addressing a nurse; maybe more of a chore-related, where people had to earn their treats. 10:13

DR. MAXWELL: So, a different sort of culture? 10:13

A. A slightly different culture, but I would have to say there was a different type of patient.

DR. MAXWELL: Yes.

A. They were admitting such a mixture of patients into the male ward that that did make a significant difference, and was something that we thought about in the planning of the new hospital. 10:13

DR. MAXWELL: So when this split between the male and the female side and it was more integrated, did some of

the staff who had worked on the male side bring that culture on to other wards?

A. I couldn't say that the -- I couldn't... I think it was more that they had to adjust to the style in the other wards and the more openness and the less restriction. But it was an opportunity for -- and there was benefits because it meant that the male staff could come over and work in some of the more disturbed female wards. Equally, the female staff could go in to the male wards and bring in more of a... I don't like to say a maternal, but a softer approach. 10:14 10:14

18 Q. MR. McEVOY: Looking across to page 20, and it's paragraph 71, here you tell us that during the 1980s, there was greater involvement from social workers and there was a move towards patients being discharged to units in the community and nursing homes. 10:15

"The process of resettlement of Muckamore patients meant I and all at Muckamore were viewing the hospital as not a "home for life", and we were to consider the potential for patients to move on from Muckamore." 10:15

Did this mark a big shift in the attitude towards care at Muckamore in the 1980s?

A. Well, obviously it came about on the availability, the regional move towards resettlement from long stay hospitals to more of community care, community living. I would say - excuse me - at that time the opportunity was there, and the majority of the patients who had 10:15

moved out moved out to it was quite large nursing homes. Many of those nursing homes actually were managed or owned by ex staff or staff from Muckamore who moved out with them. So, the attitude or the view of the staff were that this was the first time it was really considered that people -- there was money there, an opportunity for people to move out to community living.

I would say it was positive because there was the choice of patients for the homes to take. What I mean by more social worker coming in, that was more of community social care staff starting to really come in to do assessments on patients and move in, move out, and obviously working with families who were open to the families moving out. Part of that success, I suppose, in moving people at that time was the confidence that they were moving out with staff who knew them.

19 Q. Mhm-mhm.

A. And that did make a change to a belief then that this is not a home for life. There were some patients who probably, we thought, could never manage, but there were some very successful resettlements at that stage that I think instilled confidence in the staff at Muckamore that this could be done if the right resources were there and the right staff were there.

DR. MAXWELL: Can I ask you, you said in the 80s they were largely going to nursing homes?

A. Yes.

DR. MAXWELL: When did the resettlement of patients to independent living start?

A. That would probably -- I would be recalling it just, but to mind it would have been 10 years later. 10:18

DR. MAXWELL: So not until the 90s?

A. Not until the 90s, as I recall. It would have been -- the start probably would have been with Trust, residential, larger homes, you know, maybe been a 12-bedded unit within Trusts that people moved out to, 10:19 and then gradually that changed to more individual or supported living.

But it would have been, and I'm thinking back, it would have been the 90s. 10:19

DR. MAXWELL: And if staff had concerns about whether people would manage in large nursing homes run by learning disability nurses, what was their attitude to people going into independent living?

A. Sorry? 10:19

DR. MAXWELL: Well, you said initially there was concern about whether patients would manage in the care homes, and then there was reassurance that these homes were run by people who worked in Muckamore and they were successful. In independent living, there is a 10:19 lower number of staff, they are not always living in. How did the staff at Muckamore view the idea of resettling people to independent living units?

A. There actually weren't -- I don't remember or recall

independent living units within Northern Ireland, or certainly within the area at that stage.

DR. MAXWELL: Okay.

A. It was much slower than England or Scotland or Wales.

DR. MAXWELL: Okay. Thank you. 10:20

20 Q. MR. McEVOY: Dr. Maxwell might feel that she's already covered the point but in terms of attitudes amongst staff and the management indeed of Muckamore in the 1980s, was there any scepticism about the concept? You've described it as positive but was there any 10:20 scepticism about the concept and prospects for resettlement?

A. I think there would have been for some individual, you know, from individual patients.

21 Q. Patients? 10:20

A. From staff about some individual patients, there would have been. But I think from what I recall, because the majority of the patients that were going out were the people who had the more physical care needs --

22 Q. Yes. 10:21

A. -- it was betterment.

23 Q. Yes.

A. And the fundamental principle was betterment. So I don't recall anything particular from the staff of... And I do recall, you know, someone who we thought would 10:21 never manage because of her physical disabilities but, in fact, moved to a small four-bedroomed bungalow in the country where all of the community primary care facilities were there, and she managed very well. That

was a great example for encouragement in the future.

24 Q. Okay. Moving forward then to page 26 and it's paragraph 94, please. Thank you. 94 and following you describe your time and experience as a ward sister on Fintona North which began in 1991, and you remained there then until 1997? 10:22

A. Yes.

25 Q. I'm going to summarise the next number of paragraphs. You describe Fintona North as being semi -- a female semi-secure admission ward which was locked, working in close collaboration with the same multidisciplinary team. The patients would have transferred between the two wards as required. Doors in Fintona South was a female ward but was not locked. You describe then that there was a policy around ground parole for patients if they were deemed suitable. You describe then management meetings every week on a Friday which would have involved the nurse in charge, social worker, day services, and the consultant psychiatrist. You recall Dr. H41 as being the consultant psychiatrist at the time, and junior doctors in training would also have attended. 10:22 10:22 10:23

You say that you found Fintona North to be difficult but stimulating at the same time. Most of the patients were detained under the Mental Health Order. Before admission, the consultant psychiatrist would carry out an assessment of the patient at an out-patient clinic or, in an emergency, by the on-call psychiatrist. 10:23

There was account taken of the availability of beds in the hospital and admissions were approved by the designated consultant.

The ward you describe as being an old style ward with bars on the windows and was a quite secure environment. It was one large dormitory with around 12 patients and six or seven side rooms. There was a seclusion room which was next door to the office. We'll come back to that in a moment. There was an office beside the main day room but it was limited from view. Then you go on to describe some other aspects of the topography of the ward. 10:23 10:24

Because the ward was semi-secure, it meant that you could keep the outer doors locked and no-one could enter without a member of staff unlocking the door from the hall. You described the rationale for that; in other words, limiting the prospect of self-harm or harm to others, or indeed where there might have been a risk of a patient absconding. 10:24 10:24

You then deal with the availability of beds. Fintona North Ward was one of the first wards built, and it and Fintona South and Movilla A and B had metal-framed windows with an opening at the top perceived as bars, and that presented, you think, a negative image. The ward was used as a training ward for medical staff as well as third year nurses, which meant that you had the 10:24

benefit of additional staff in the form of a specialist registrar. Apart from those trainees, it was practice in Muckamore that all staff allocated on a permanent basis on the wards had worked elsewhere with people with a learning disability and therefore had some experience. 10:25

You say it was a challenging environment for staff to have worked in. There was a high risk of physical assaults by and threats from patients. You say it was emotionally draining. A large part of your role as Ward Sister beyond the care of patients was providing support to staff. You say you had to quickly address concerns they might have had. 10:25

Patients were encouraged to attend day care, recreational activities and church services and so on. There were limited space for patients' personal possessions. There were patients with very challenging behaviour in Fintona North, and significant aggression issues as between patients and between patients and staff. 10:25

Then at 105 you deal with the seclusion policy within Fintona North, and you say that you worked according to the seclusion policy. 10:26

"This included the nurse in charge of the ward contacting the duty doctor on-call and the duty Nurse

Manager to inform them that a patient had been placed in seclusion and the reason why that had been done." You don't recall the date but you do recall that when the policy was reviewed, a member of staff was allocated to remain with the patient by observation through the door window and making a record of this at least every 15 minutes. The details were reported on the day or night report as appropriate in the patient's care plan, in the patient's medical notes, and would then have been discussed at the weekly MDT meetings. 10:26

"The policy required that there was always a qualified member of staff who made the initial decision to seclude the patient, and justified the decision in the patient's care plan and to more senior staff if they were not the nurse in charge of the shift." 10:26

You tell us you were part of the review of the seclusion policy and you would have fed your opinions into it. That also included Mental Health Services from Knockbracken. 10:27

CHAIRPERSON: Could I just ask you to pause for a moment because my Caseview has packed up. I don't know if anybody else? 10:27

DR. MAXWELL: Mine has now packed up.

CHAIRPERSON: Everybody, right.

[To the witness] Sorry to interrupt you. We've got a

transcript. Let's just try reconnecting. I actually had a problem yesterday as well but I managed to reconnect. Yes, we're back on. Just give everybody the chance to do what we have just done. Has everybody reconnected? Okay. Sorry. 10:28

26 Q. MR. McEVOY: In terms of the operation, you've describe the basis of the policy and the mechanics of it. How often do you recollect it being used? I know it's sometime ago now but was it something that was used frequently within Fintona North? 10:28

A. Yes, yes, yes. It could have been daily but it was, like, several times a week at minimum. You had good days where it wasn't used but, yes, frequent use.

27 Q. Were there environmental factors which might have contributed to it needing to be used? 10:28

A. Absolutely.

28 Q. Can you give us an idea of what those might have been at the time?

A. Overcrowding. Lack of space, private space for patients, including their bedroom area and other day 10:28 spaces. The mental health and the physical health of the individual patients who may have been going through particular difficulties or having medication changes, and just their whole, their whole presentation, the behaviour had been more challenging. Other factors 10:29 included the mix of patients. Like, for instance, if you suddenly had a new admission or something that was taking up more staff time, that meant you had maybe less resources on the ground, so to speak; that could

have been a trigger.

29 Q. Yes.

A. Other triggers were meal times. Or just maybe some disappointment and friction between patients as well.

30 Q. At 106 you say: 10:30

"If the patient was in the hospital as a voluntary patient, the nurse in charge and the doctor/consultant and others would have reviewed their legal status as a voluntary patient in seclusion." 10:30

You would have alerted staff members and also discussed this with family members. You found that in those scenarios, it was quite usual for the patient to become a detained patient under the Mental Health Order. 10:30

I suppose what I'd maybe like to know, and if you can help us understand it, is what you're saying there is that the act of seclusion having the consequence then that a voluntary patient could become detained? 10:30

A. Yes. So if somebody was admitted voluntary, it was a voluntary admission, maybe a new admission, and something happened that the need was felt that seclusion was the only way to contain them in that emergency situation, there would have been immediate 10:31 alert to the fact that, you know, to turn a key in the door you were actually secluding somebody who was voluntary.

31 Q. Yes.

A. So that would have had an immediate contact with the medical staff. You know, so if the consultant wasn't in the hospital, they were contacted or somebody was contacted immediately. It may have been a very short episode; it may have been that the door just needed to be locked for five or 10 minutes and just somebody just calm down enough to allow a staff member to go in to diffuse the situation. That would have been taken seriously and discussed, and discussed obviously with family and so on, but that may not have led to immediate consideration of a Form 6 or whatever from the Mental Health Order. 10:31 10:31

Had it been something more serious where the person was not settling, or had been a repetition of something that had happened before, then serious consideration was given and the patient may have been detained. But under the Order, obviously that would have been reviewed within the different forms. 10:32

PROFESSOR MURPHY: Can I just ask, given what you've just said about all the effects the environment had on patients, it sounds like for some patients those effects were so painful and difficult to deal with that they lost it -- 10:32

A. Yeah.

PROFESSOR MURPHY: -- ended up secluded and then ended up detained, which makes it sounds like the hospital is making people worse.

A. Yeah.

PROFESSOR MURPHY: Is making them detained because the conditions are so bad?

A. Yes. I understand what you're saying and how that might appear, but I think it's to emphasise that this person who was voluntary, it was a question of immediate alert to a consultant and to senior management that this is a voluntary patient who came in voluntary and we were placing them in. And I accept that the trigger may well have been the environment, but still the way that the person was presenting at that time, it was felt to be the only safe way to contain them. 10:33 10:33

As I said, it wasn't that it would have been immediate detention there and then for a five-minute situation. That still would have been reported through and discussed and discussed in-depth at the multidisciplinary meeting. But if something was requiring a longer period of time, or happening very often then, the patient's legal status was considered. 10:33 10:34

PROFESSOR MURPHY: I mean, I think the tricky thing is that it's making it sound as though the hospital was making people worse, and maybe it was. Was there no discussion of how to tackle the environmental issues that were bringing it about, like the overcrowding, like the mix of patients, like the level of noise? 10:34

A. Yes, there was, and always was what could and would we do any different. That was exactly why we pushed hard for the new hospital and the benefits of the PICU in

Cranfield that would deflect. I mean, that was one of the things of the focus groups that was very much talked about within the de-escalation of aggression and the lack of MAPA training would have been the triggers, how to avoid having to use the seclusion. But with the opportunities of the buildings, of the number of patients that we had at that time, there was no alternative.

PROFESSOR MURPHY: Okay. Thank you.

DR. MAXWELL: Can I just ask about the (inaudible) England, I know under the mental health account, RMNs, mental health nurses, can detain people for a short period of time -- 10:35

A. Six hours.

DR. MAXWELL: -- pending an assessment by an approved social worker or psychiatrist. Did the nurses at Muckamore under your legislation have that power? 10:36

A. Yes, under Form 6 of the Mental Health Order.

DR. MAXWELL: So you were legally detaining them and putting them in seclusion pending an emergency assessment by a psychiatrist? 10:36

A. Yes.

DR. MAXWELL: So when you say it was quite usual to become detained under the Mental Health Order, do you mean this temporary holding? 10:36

A. Yes, the temporary holding. Yes.

DR. MAXWELL: It may not have gone on to a permanent detention?

A. Correct.

DR. MAXWELL: Thank you.

CHAIRPERSON: That's exact -- that's very much what I wanted to ask as well. Because if a patient is voluntary, they are volunteering presumably to abide by all the rules and regulations of the hospital, one of which is that, in certain circumstances, they can be put into seclusion. Just help me, why does that trigger a consideration of whether they should then be detained, because they are voluntary but in seclusion? 10:36

A. I think it was where it was happening for a long period of time, felt to be happening for more than a five-minute or a 10-minute time maybe where other staff had to come to help or deal with it. It was just -- it was the consideration at that time that it was not ethical to lock up somebody. You know, somebody was coming in for treatment; seclusion wasn't something that we probably highlighted as a treatment plan, it was an emergency situation response when everything else had failed. 10:37

Now, there were some patients, prior to admission and discussion with whoever was referring them, that this may be something that they would need, but that was very few that you were actually thinking that planned seclusion room was part of the reason for admission. 10:37 10:38

CHAIRPERSON: Okay. But there were circumstances in which, for instance, frequent seclusion or long seclusion --

A. Yes.

CHAIRPERSON: -- could lead to a review of whether they should be detained?

A. Yes. Of course if their detention -- if they were detained, that was reviewed, as you said, doctor, with the six-hour holding. Or there again after the two weeks and whatever, it was very much reviewed. And obviously reviewed with families as well. 10:38

CHAIRPERSON: Thank you.

32 Q. MR. McEVOY: Looking across to page 31 and paragraph 117 to pick up on seclusion here, you say that, as you recall, the next-of-kin was always informed when someone was placed in seclusion for the first time? 10:39

A. Mhm-mhm.

33 Q. Would that have been regardless of whether or not it was a brief five- or 10-minute? 10:39

A. Yes.

34 Q. Or longer?

A. Yes. In Fintona North that certainly would have been the case.

35 Q. How quickly after the event of seclusion would you have notified family members? 10:39

A. As soon as possible. It could have been -- it would have depended on being able to get the situation under control, first of all. If somebody had been in for a very short space of time, they may well have been out before you would have had time to speak to family. Sometimes people weren't available until later on in the day or the night, or, if it was overnight, it could have been the next morning. But the first available 10:39

opportunity certainly within the shift.

36 Q. Okay. Overleaf then at page 32 and paragraph 124, a few moments ago, in fact, you had made mention of MAPA, and effectively in this paragraph it replacing C&R, or control and restraint. 10:40

Can you recall the extent to which, if there was an extent, the MAPA training differed from control and restraint?

A. Yeah. Control and restraint was actually care and responsibility. 10:40

37 Q. Right.

A. It was -- MAPA became the holds were different, the actual physical holds were different. With care and responsibility, if the patient struggled with you, particularly in a hold of the hand, if the patient pulled, they could inadvertently cause themselves pain by struggling in the hold. That's one example that sticks in my mind about care and responsibility. And I was a trainer for both. 10:41

The holds with MAPA were more, I would say, gentle holds but more of a whole body hold. You weren't just concentrating, say, on a wrist or a thumb hold.

38 Q. Yep. 10:41

A. And the approach from MAPA was more of a whole care plan type approach for each patient.

39 Q. Yes.

A. The follow-up was different and the audit was

different.

40 Q. Indeed, you say that in the next paragraph. You say it was about de-escalation and looking at the care plan for the patient. At 126, you say MAPA was --

DR. MAXWELL: Sorry. Just before you get there, you said a patient under care and responsibility might injure themselves because you're just holding their arm and MAPA became more of a whole body containment. Are you suggesting that the patient was less likely to be injured under a MAPA hold than a care and restraint hold? 10:42 10:42

A. Yes, in my opinion.

DR. MAXWELL: Thank you.

41 Q. MR. McEVOY: At 126:

10:42

"MAPA was commissioned by the Eastern and North Western and Social Care Boards and there was more of a detailed analysis and audit with the MAPA system. There is a designated person for monitoring MAPA at Muckamore."

10:42

Can you tell us more about that designated person? Is that a member of staff?

A. Yes. Yes, that was a member of staff. It was a Senior Nurse Manager who was... So with the MAPA, each organisation, as I understand it, had to have an identified -- I can't actually recall the name of the title the person had, but they were the coordinator, for instance, who were the named person with the organisation. He or she was responsible then for 10:43

reviewing all the audit forms, and for, within Muckamore, for ensuring people's training was up-to-date for the link-in with the main organisation in England and the network, and reporting back through to the core hospital management team and others.

42 Q. Okay. Was there somebody monitoring that monitoring, if you like?

A. Yes.

43 Q. Who would that have been?

A. Yes. All of the MAPA -- there was a monthly report, for instance, that came to the core hospital management team, which I chaired. That report would have also gone to the medical staff team. Each ward would have had a monthly report on the total of MAPA incidents for review. There would have been presentations, I think, if need be to -- it went in through governance risk to the Trust. But also the overall, I think it was Positive Options, you call the organisation --

44 Q. Yeah. I think so, yeah.

A. -- would have been linking in with the coordinator about the use of, and review of, particular holds. For instance, prone position became very -- not dangerous but unlikely or not the preferable position. Any kind of new research or anything like that would have been brought to our attention via that route.

45 Q. Over on page 33 of paragraph 131, again thinking back to your time in Fintona North, you talk about how, in addition to MAPA, there was training in relation to personal relationships, social skills, psychotherapy

and counselling, and gradually nursing staff were trained and the Behavioural Nurse Therapy Unit expanded at Muckamore. You say that other training began to emerge, such as Tizard applied psychology.

10:45

Did that have any effect, the use of that particular approach, on the practice on the wards?

A. Very much so. Prior to this, there were obviously staff who had been trained in behavioural approaches and worked within the Behavioural Nurse Therapy Unit 10:46 out of the ward within the social training centre building. By commissioning nursing staff from the ward, this was the new approach, that that nurse went and did the course but she remained within the ward; she didn't go and work off ward. 10:46

So we had patients who left the ward, went to behavioural nurse therapy, worked on a programme, the programme was brought back to the ward, but because the therapist didn't actually work on a ward, they didn't 10:46 see the whole 24-hour patient experience. By bringing the nurse back onto the ward to do her pieces of work, to look at other ways of working, made a big difference. It encouraged us to -- I suppose at the first stage when H177 went, from my point of view, it 10:47 was a test to see how good, how effective this would be. Very much so it was a course that was commissioned then for a good number of years, and there were many nurses from other parts went.

But definitely bringing that behavioural psychology approach was different; it was an introduction away from the medical model of not just but traditional behaviour modification as we would have known it and, I suppose, reliance on medication. 10:48

DR. MAXWELL: Can I ask you roughly what year you started sending people for that training and then coming back to be based on the wards?

A. Mid 90s. 10:48

DR. MAXWELL: Mid 90s, okay.

46 Q. MR. McEVOY: Over on page 34 then at 136, and this is something we've talked about already, which was the atmosphere, so to speak, on Fintona, instances of patient-on-patient violence, and you've described the environmental factors in detail a few moments ago. Do you recollect during your time on that ward there being any discussions about ways to solve it, solve the issues on the ward? 10:48

A. Weekly. 10:49

47 Q. Yes.

A. Weekly, at multidisciplinary team meetings, anything that had happened was recorded, was discussed and they were always looking at ways to try. I mean, that could have been -- well, obviously one way would have been maybe increased supervision levels for certain patients. 10:49

48 Q. Yep.

A. It would have been the triggers of were there two not

getting on, could we separate it into different areas of the ward; could somebody move to the ward Fintona South next door.

49 Q. Yep.

A. Was there ways of using day space, for instance, within day care at weekends to split the groups up and to give more space. There was the use of the daily recreational activities and who was going, and were these all being utilised. 10:49

50 Q. Do you recall there being any discussion in terms of - I'm thinking about the levels of noise and distress that you described - splitting the ward up into smaller units? 10:50

A. Yes but it wasn't possible because of the layout of the ward. 10:50

51 Q. Yeah.

A. You had two large areas. I mean, we used every storeroom and cloakroom that was possible to create extra space, but it was actually the physical layout of the ward. 10:50

52 Q. Okay. Turning over then to page 37 to paragraph 144. After your time on Fintona North -- sorry, in 1997 you assumed the role as Senior Nurse Manager on Fintona North and South and Movilla A and B, and the forensic ward in addition to that. And Mallow Ward was the unlocked ward which became the forensic ward? 10:51

A. Yes.

53 Q. Prior to 1997, had there been a recognised forensic ward in the hospital?

A. No. As I maybe alluded to earlier, that was one of the problems with Movilla A and B --

54 Q. Yes.

A. -- because the men who were being admitted from the courts under hospital orders, or for assessment, were placed in the ward with other admissions, which could have been somebody with onset of dementia. That was very much a big mix. 10:51

So I can maybe elaborate on that slightly? The forensic ward, the open forensic ward, actually was Mallow. Sometime around the early 90s, there was a lot of work done by -- there were two consultants and a consultant -- medical consultants. Sorry, a consultant psychiatrist, and a consultant psychologist who had a particular interest in forensic, along with the Ward Sister of Mallow, obviously under the direction of the site director, who was the chief nurse in the hospital at that stage, moved, created a forensic setting within Mallow, moved the men from several wards to the one ward, put a lot of in-service training/team building, and founded then what became then led to Six Mile in the new hospital. 10:51 10:52 10:52

55 Q. Yeah, okay. In 145 then you tell us, just the following paragraph, that you were involved in the reprofiling of the hospital in 1998, which followed a patient's census in 1996. 10:53

Do you remember what it was that triggered that census?

A. There was a regional -- that was regional approach. That was led by the Eastern Board.

56 Q. Okay.

A. It was, I think, the target that so many patients would be resettled by 2002, I think it was. 10:53

57 Q. Right.

A. It was led by Eastern Board.

58 Q. So something from Board level?

A. Yes. Yes.

59 Q. Okay. Overleaf then on 146, the reprofiling which began in 1998 involved 180 patients being moved wards. You were very involved at that time with the moving of those patients to nurse them together. The idea was derived from consultations carried out in relation to community care, and community care was encouraged if available. 10:53 10:54

Did the consultations involve next-of-kin and family members and carers?

A. Yes. Yes. 10:54

60 Q. Can you tell us about the consideration that was given to the impact on patients of moving them from a setting they were familiar with during that exercise?

A. Yeah. It was a big consideration, particularly for some of the patients who were maybe very autistic and used to their own area. It actually wasn't such a big problem because there were groups of patients moving to a new area with staff that they were familiar with. For instance, their day care didn't change and there 10:54

was actually -- I don't recall. It was an awful lot of work, physical work in getting it done, but I don't recall particular upsets that are significant around, you know, patients going to a ward and not settling there. There was ways it was managed; it worked quite smoothly. Because there was a good preparation and lead-in time to it as well.

61 Q. So you don't recall the Ward Managers and so on having issues with unsettlement or feelings of disturbance among patients? 10:55

A. I would -- from memory it would have been you would have been aware that you may need additional staff on, for instance at night, or at times to just get people settled and familiar with their surroundings. But by the nature of the patients, there wasn't a lot of disrup -- you know, stress. 10:56

DR. MAXWELL: You say there was good preparation. What was done in preparation? How were the patients prepared? How were the patients informed?

A. Well, I think in fairness a lot of the patients wouldn't have had the cognitive ability to realise that they were being moved at that stage. For those that did, it would have been... Well, when I say patient focus groups, it was down to the named nurse explaining 'and we are going to be going' and taking them. I can recall maybe taking them to see where they were going to be moving to. And packing their staff and picking their beds, where they were going to be sleeping, and moving with their friends, and moving. So there was 10:56 10:56

that kind of preparation.

It was maybe -- when I say there was a good lead-in, it could have been a couple of months. It wasn't just something we had do in a day or two. 10:57

DR. MAXWELL: And you also said you moved the staff with the patients?

A. Yes.

DR. MAXWELL: Was that a conscious decision, basically you kept the same staff with the same patients? 10:57

A. You wouldn't have moved all the staff but you would have moved a significant number that, yes, they were familiar with staff.

DR. MAXWELL: Because we've heard when there were moves later after you retired, that didn't necessarily 10:57 happen. But that was a conscious decision?

A. Oh absolutely, yes. It wouldn't have necessarily have been yes, it'd had been some of the qualified staff, but it was particularly the unqualified staff that would have moved with them. 10:57

DR. MAXWELL: Because they did most of the personal care.

A. Absolutely.

CHAIRPERSON: But then wouldn't that have had the effect of leaving the ward short? 10:57

A. No, because there'd been -- there was -- you were moving different groups to different wards. So maybe say it was ward -- we'll say it was Greenan, they were moving to Greenan for instance, and you were taking

patients from Moylena, there'd have been staff moved back into the other ward. You know, the staff, it was adjusting the staff to actually changing over to be with patients.

10:58

The bed numbers didn't change, it was just the grouping of where they were residing, where they were being treated. So if you were being considered for resettlement, you had no active weekly input from the multidisciplinary team, you were able to go to that ward and there'd have been a number of staff went with you. But say you had 10 qualified staff, maybe four of them went to that ward, six of them stayed, you know.

10:58

It wasn't all the staff that went because the patients on that ward would have been going to different places, so you had to have a substantial amount of staff left behind.

10:59

CHAIRPERSON: Thank you.

62 Q. MR. McEVOY: Okay. At paragraph 147 you talk about funding and challenges around funding. You also mention then - we'll come back to the funding in a moment - you mention the formation of a resettlement team. Do you remember when that was? Roughly, the year?

10:59

A. Around about the year '99/2000, around about then.

63 Q. Okay. A ward resettlement officer was employed to identify people within each of the Trusts that the various patients came from?

A. Yeah.

64 Q. The resettlement -- sorry, do you want to say something about that?

A. Yes. Just to explain that that was somebody from within the team but the funding, the Boards, the Commissioning Boards, agreed to finance a member of staff to head up as the resettlement officer within the officer. In this case it would have been a staff nurse whose dedicated duty was to be the resettlement officer for that ward and liaise with the community Trusts on a daily basis nearly, as well as report back on a weekly basis as to... 11:00 11:00

65 Q. Was the convention then that that was normally a nurse?

A. It was normally a nurse. Yes, it was. I have to say it didn't last; it only lasted for one/two wards. 11:00

66 Q. Right.

A. And then the whole resettlement programme slowed up.

67 Q. Yes.

A. And that post then was recuperated. Again, it wasn't funded. Or the role, I suppose, was taken up within community teams rather than the hospital staff. 11:00

68 Q. Yes.

A. I think it was important at the start, it was a good idea at the start because it gave the hospital staff and the families the confidence that this was somebody who really knew the patients who was taking on this role. 11:01

69 Q. So when do you think it would have been absorbed then by the community?

A. Probably mid-2000s.

70 Q. For those patients you describe in the paragraph who were identified as suitable for resettlement, they went to Finglass while the resettlement team had worked closely with the Trust to find them a place to resettle; was funding available, was sufficient funding available at that time for those patients? 11:01

A. Yes, from what I recall they were. If I recall correctly, Moyola was the first ward that closed and resettled, and then Finglass. The majority of the patients were found placements, satisfactory placements within that sort of first year, 18 months, which led to closure. There may have been a few who had to move to other wards because their place wasn't finalised -- 11:02

71 Q. Yes. 11:02

A. -- or it was felt they weren't well enough to actually move out.

72 Q. Chair, I'm just mindful of the time. The witness has been going for about an hour.

CHAIRPERSON: Yes. If that's a convenient point for you, we'll take a short break, but you have quite a way to go, haven't you? 11:02

MR. McEVOY: I am about, I'd say... We'll finish before lunchtime.

CHAIRPERSON: Okay. I'm just thinking if we take a break now, it's going to be a very long haul. It might be sensible to keep going for 10 minutes, if you can do that. 11:02

MR. McEVOY: Yes. Now, looking at paragraph --

CHAIRPERSON: Sorry, I should have asked you.

A. Oh, I'm fine, thank you. I'm fine.

CHAIRPERSON: Sorry, Mr. McEvoy.

73 Q. MR. McEVOY: Looking at paragraph 149, you tell us that it was proposed that one ward per year would be dealt with by way of resettlement. The problem arose when the wards were left with only six or seven patients. Can you recall when that problem arose? 11:03

A. Yeah, It would have been maybe mid 2005, 2004-2005. The first wards closed relatively well and within the period, but then things slowed up because the facility, the community placements weren't there or funding had changed. By that stage, there were -- the patients who needed the physical care and went to the nursing home type, or residential homes, had gone. Now it was more of the challenging behaviours. 11:03 11:04

74 Q. Yes.

A. And also then there was more of the independent sector provision becoming available and more of a supported living style. 11:04

75 Q. Yeah.

A. So things slowed up.

76 Q. You've described the funding issue arising from the money having to be spent in community facilities; finances were moving out of the hospital to community facilities. You describe various scenarios where there might have been only two patients left on a ward when there might have been 10 previously. There were issues where the costs of the beds coming out of the budget of 11:04

a doctor or a psychologist, and it was impossible to release portions of funding. You then describe an understanding with the Health and Social Care Trust that this resettlement process needed to happen and they had to "suck it up", as you put it, until the ward was --

A. Absorbed. Sorry.

77 Q. No, no, it makes the point. Until the ward was closed and then the money could come out of the hospital fully. Overall, sometimes what appeared to be a cost saving did not result in a cost saving. So therefore you describe the example whereby a patient was moved from a ward that was closing, the hospital would close one ward and then make that saving; the patient was moved to a new ward in the hospital requiring a higher level of observation on the new ward, with the effect that there would then be a higher cost to the hospital. You said that this changed later in your experience under the Belfast Health and Social Care Trust when Miriam Somerville was informed that you had to close Fairview, which was down to under 10 patients. You come back to that later in your statement.

I suppose the Inquiry would be assisted if you could tell us if you remember any issues, or any requests essentially, for what is sometimes called dual or double funding, even on a transitional basis where those situations arose; in other words where occupancy diminished below, I suppose, a viable level?

A. Well, certainly I recall within North and West Belfast Trust whenever were in that situation, that you were down to maybe eight/nine, you know, obviously there was finance meetings monthly with the finance officers from the commissioning boards, the business manager at the hospital, and I would have been included and the director of the service would have been included in all of that discussion as well.

The agreement for bridging would have been very carefully monitored, but it really came about because if it was down to two, three, four patients, the ward was obviously closing for the financial benefit of the heating, lighting, the whole infrastructure et cetera. But the patients that were moving to the new ward, they were the ones who maybe where there was going to be problems, heightened problems, and there was heightened staff observation, which was the main reason for the cost from the nursing point of view.

78 Q. Yes.

A. For money being needed to increase the nursing budget there. Also, as I have said, because each ward had its funding for pharmacy, dentistry, medical whatever, and that would have been obviously a discussion at the commissioning and contracting meetings. But there was an agreement or an understanding that bridging was granted, certainly in the first few resettlement wards.

DR. MAXWELL: Can I ask, you talked about the first wards to close, it was quite straightforward, and you

talked about those patients being people with largely physical disabilities and so nursing homes were able to absorb them, and then you were left with patients with challenging behaviours. I guess that also means a lot of people with autism for whom change is much more difficult, even if it's change from one ward to another. Was there any understanding at resettlement meetings, talking about different types of patients and the way in which resettlement programme should run should be different for patients with different needs? 11:08 11:09

A. That certainly did come in. There was a regional resettlement group run by somebody from the Department --

DR. MAXWELL: Yes.

A. -- where everybody attended from every Trust, and the independent sector, the housing associations et cetera, and the representative of the families. So that did come in definitely later on. I think there was maybe an interim few years where that wasn't just as clear; I don't think the understanding was just as clear. But definitely prior to my retirement, you know, back in to the latter end of the 2000s, there was a very clear understanding. There was a lot of benchmarking done across the water to help people realise that the money that was going to be necessary to deliver that for the more autistic type patients. 11:09 11:09 11:10

DR. MAXWELL: So I think it's two parts. One is understanding different placements required in the community; you couldn't just put them into care homes

as had happened with maybe the first cohort. But I'm also thinking about Muckamore, so the idea that, you know, we could merge two wards because it would save money; was there any recognition that not only was it more expensive because you needed more nurses, but it was the opposite of betterment for these patients? They were relatively stable in one ward -- 11:10

A. Yeah.

DR. MAXWELL: -- and they were being moved for economic reasons, which was distressing them, which was leading to needing more nurses to do observation. Was there any recognition that this was doing patients harm? 11:10

A. Yes, very much so. In the -- prior -- the only one ward that I had the problem with was the Fairview that I have mentioned there, because for the other -- for the other wards, there was definitely a lead-in and looking at all of those aspects. That maybe included some minor work that had to be done in the receiving ward maybe to create a smaller day space or an outside space or whatever was necessary for that patient or going to help, you know. 11:11 11:11

You didn't -- the last thing we needed was too many staff or too many extra bodies on top of another ward, because there were people who were living in the receiving ward that you didn't want to be disrupting either. So there was a lot of thought and preparation went into that. 11:11

DR. MAXWELL: In your professional opinion, if there

had been money, would you have kept people on their ward even when they were down to two? If that had been possible, would that have been better for patients?

A. Not on the ward as it was because it was too big and, you know, they missed -- they missed the buzz of everybody else that left. There was an effect on people who had been left behind in seeing people -- they may not have had great verbal communication but they knew what was going on and something was very different. I think it was, I think it was still right to try and use space within the hospital and do any necessary adaptation that had to be done, and obviously include the families. But I think the way that Fairview was done with a larger number and so quickly was detrimental. 11:12

DR. MAXWELL: Thank you.

CHAIRPERSON: Shall we take a break there, if that's convenient? We'll take a 10-minute or so break.

Thank you very much, we'll see you back in a few minutes. Okay. 11:13

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIRPERSON: Thank you. Mr. McEvoy, just to say obviously if you feel you can't finish by lunch, please don't rush it. We've got reading this afternoon, and if the witness needs to go into the afternoon, we can do that. 11:27

MR. McEVOY: Thank you. Thank you, Chair.

79 Q. Mrs. Steele, can I take you then to page 40, and it's paragraph 155. Thank you. Here you talk about the quality department within the North and West Belfast Trust which was headed up by H287. You say H287 led on 11:28
driving quality improvement and standards to the extent that the hospital obtained four Charter Marks. The Charter Mark is a roadmap used to reduce services; bought in processes to help people who could not read access information. It looked at the core standards 11:28
and expectations and the introduction of a patient-centred care plan. The awarding of four Charter Marks for one hospital was unheard of in the United Kingdom.

11:29

Can you tell us a bit more about what the Charter Marks were for?

A. The Charter Marks was for all of the services on site. It was everything that happened within the hospital but it was primarily around information, quality of the 11:29
service, communication between departments, access, and the very fabric of the buildings.

CHAIRPERSON: Sorry. In paragraph 154 you're talking about 1996; when are you talking about in paragraph 155? 11:30

A. That followed on. I think the first Charter Mark maybe was 1997.

CHAIRPERSON: Right. Thank you.

A. '98. The Patients Charter obviously gave the patients

their independence -- their individual named consultant, named nurse, named social worker; made sure every patient then had their own day care or was entitled to day care. So whenever we worked towards Charter Marks, it was looking then at all the services that were available to the patients. But it provided -- it was really very much an audit of the services that we were delivering. To achieve a Charter Mark, you had to obviously work with the standards that were expected of Charter Mark, and that included the care plan for the patient, the information that was available, the consultations. 11:30 11:31

PROFESSOR MURPHY: So were there four Charter Marks in four successive years?

A. No, no, no. I think it was '97, 2001, 2004, and 2007, I think. 11:31

PROFESSOR MURPHY: Right.

A. So it was everything from the documentation in the nursing care plans to the doctors' files to the service that was provided by catering. You know, it was the support services. 11:31

DR. MAXWELL: Is it fair to say then that the Charter Mark was actually a measure of the extent to which the hospital had implemented the rights under the Patients Charter -- 11:31

A. I would say that's --

DR. MAXWELL: -- and actually you could get a Charter Mark for different parts of the Charter?

A. Mhm-mhm.

DR. MAXWELL: So you could get one for communication and not necessarily get it for another part?

A. Yeah. Yeah.

CHAIRPERSON: And I should know this but who grants the Charter Mark? Who decides that you should get a Charter Mark? 11:32

A. There was a...

DR. MAXWELL: I think it came from the Prime Minister's office.

A. I was going to say it was the Prime Minister's office, as I recall. Yeah. 11:32

DR. MAXWELL: Because it was John Major who brought in the Patients Charter, wasn't it?

80 Q. MR. McEVOY: Looking across to page 41, paragraph 160. As part of the Charter Mark scheme, you tell us about a new audit tool which was developed called EQC, or Evaluate Quality Care, in the mid 1990s? 11:32

A. Yes.

81 Q. And that was headed up by H840 initially?

A. Yes. That actually evolved. There was one just prior to the Evaluating Quality Care, which was Equate. It was based on the monitor tool that was used within the health service more in general hospitals. I don't know if I can say the lady's name who was the senior nurse. 11:32

82 Q. Check; if you check your cipher list, you may see her there. 11:33

A. It was H840 --

83 Q. I think I've just mentioned her anyway because you have mentioned her in your statement.

A. -- who was the senior nurse who had the responsibility for quality. She would have been going to all of the conferences that were available and benchmarking where she could on all services. So she came back, or she tried to implement monitor within the Learning Disability Services but it didn't just fit, there was too many other aspects of care that didn't fit within the tool that was used within general hospitals. So there was a multidisciplinary working group got together and developed, added to the basis of monitor to create this new audit tool, which was initially Equate, which was more or less just for nursing aspects and care plan and such. Then eventually that went on to Evaluating Quality Care which took in the whole, every department. 11:33 11:34 11:34

84 Q. So beyond nursing?

A. Beyond nursing, yeah.

85 Q. Is that something -- I don't suppose you have retained a copy of it, do you, have you?

A. I haven't retained a copy but a copy should be ... 11:34

86 Q. You would expect?

A. I would expect it to be, yes, because it was widely -- it was widely advertised and there were other people interested in purchasing it at the time. So it was an official... 11:35

87 Q. Six monthly audits were carried out then as part of EQC; is that right?

A. Yes, that's right. So I would make the significant point there that the audit team, whilst initially they

were all within the hospital, it could have been the estates manager or member of staff coming in along with a nurse to actually audit. It wouldn't have been the whole, it would have been sections that would have had an audit every six months. Then that was reported through to the quality manager, the lady that I mentioned and, you know, the reports. We had a -- there was a resource person who collated all the reports, and that was reported then through then to the hospital management team and to all departments, and up to the quality department within the Trust. 11:35 11:36

88 Q. Do you remember anything about the outcomes of those audits?

A. Yes. They were -- they were really -- I can recall that maybe, maybe an audit showed up that the standard of the care plan wasn't correct, or that, for instance, medications hadn't been reviewed within the appropriate time. There was an action plan for every visit, for every audit. I think the aim was something like 95% and if you were below that, you wanted to know why. 11:36 11:36

There was people, surprisingly, took an awful pride, Ward Managers took a pride and didn't like any drop in their -- and people took it very, very seriously, it wasn't just a sort of token exercise. But it would have been as simple things as, for instance, there was no evidence of patients rights displayed, or, you know, talk to patient groups as well who could communicate. 11:36

89 Q. How long did it continue in use for?

A. It was still in use when I retired.

90 Q. Okay.

CHAIRPERSON: Sorry, can you remind me when that was?

A. 2011. 30th September 2011.

91 Q. MR. McEVOY: Moving across then to page 45, the very bottom of the page, the start of paragraph 172. Here you tell us about how the hospital had previously been run by a matron. This role was replaced by the role of a Director of Nursing within the Belfast Trust then. When would that have been? 11:37 11:38

A. Well, actually matron retired in 1980, I do believe. Her immediate role was taken over by, it was a site director at that time.

92 Q. Yes.

A. So he would have been reporting through to the unit of management that ran Muckamore at that stage. It moved to the Director of Nursing in the Belfast Health and Social Care Trust in 2000. 2000 actually it became the community unit of management, North and West Belfast community unit. At that stage then it came under the Director of Nursing and became the Trust in 2004. 11:38 11:38

93 Q. Yeah, okay. Then you describe how you reported to - and this is overleaf, just the next paragraph - you reported to Brenda Connolly on professional issues, Norma Evans until 2002, and then Miriam Somerville as Director of Learning Disability and operational and managerial issues. You describe how Ms. Connolly was a very visible presence in the hospital. She often would have walked around the wards to find out more about 11:39

performance. She was responsible for staff and workforce planning. Something you've indicated, also responsible for quality and compliance with the Patient Charter applications. On a personal level, you found her to have lots of empathy, sensible and understanding; you weren't afraid to speak to her. She wanted to know what was going on and would have responded to you. You were a ward sister and she took the time to stop and listen to you, and you witnessed her doing that with others. She gained a lot of respect from staff and they had for her; didn't fear her. You're also complimentary about her approach to nursing at the hospital, which was positive. 11:39 11:39

When the change came from the matron model to having a Trust-based director, did it become more important that the nursing director visited the hospital, walked the wards? 11:40

A. Yes. Well, matron had been there for so long and was so well established, as you know, there. I think -- can I just correct the dates, it was 1990 that it changed to the community unit and then '94 to the Trust. 11:40

94 Q. Thank you.

A. I think because it was a new organisation, the Director of Nursing made her -- it was the only hospital, of course, within the community unit and in the Trust. As well as herself, the Chief Executive of the Trust and the Director of the hospital Community Learning 11:40

Disability Services had a background in learning disability; they were social workers with a history. So, there was an emphasis on the hospital and an interest that maybe, maybe, you know, matron wasn't seeing or I would say the unit of management wasn't seeing. So, whenever the new North and West took over, aspects of the hospital were highlighted, which meant the big role of the Director of Nursing was to be down and report back to the Trust Board. 11:41

95 Q. Okay. In the following paragraph then at 175, you talk about how you worked with Ms. Connolly and Molly Kane and Maureen Ferris, who were the nursing officers from the North and Eastern Trusts respectively, on many issues including workforce planning and planning new services such as the new hospital. 11:41 11:42

Can you tell us about plans for the new hospital and, for example, the business case around it?

A. Yeah.

96 Q. How it was developed. 11:42

A. The work around the business case, maybe I could say even with the ladies even before we got as far as the business case, some of the issues that we would have been negotiating around were exactly because of the reprofiling and the move of patients where needs changed and the budget had to be -- levels of supervision changed, which meant enhanced staffing. 11:42

The business case, there was many long discussions and

debates about where the future of Muckamore Abbey services would sit, and where it would be. That was led by the Eastern Board as well. I recall discussions/decisions around 1997, I think, when there was a public meeting in Lisburn that was -- that was led, I think, by the Parents and Friends, about not closing Muckamore, about Muckamore being the site for the new services that were going to be needed. I think there was recognition that the big institutional hospital wasn't the way to go; hand in hand with the community expansion and what was hoped for for people with a learning disability. 11:43 11:43

So, whenever the decision then was taken that the new provision within Belfast would remain on Muckamore site, then there was a business case was prepared, and there was a steering group obviously then set up for all of the relevant disciplines to take part in. 11:44

97 Q. Okay. Looking across then to page 54 and paragraph 192. Now, this is touching on the slightly more negative topic maybe than we have been dealing with, but here you talk about a complaint which you had which was connected with the murder of Trust areas in 2007. Here you talk about your attendance at the Director of Nursing meetings. 11:44 11:45

Can we just understand what you mean by that. Was your complaint about having to attend the meetings, or was it something else?

A. I would welcome the opportunity to explain this point.

98 Q. Of course.

A. I was used that the North and West Belfast Learning Disability featured very much at every discussion and every level. Mental health had their own managers who attended the director -- we all did; the senior managers all went to the Director of Nursing meeting. When the Trusts merged, I wasn't invited to be part of the voice for learning disability at the Belfast Trust. The Director of Nursing -- the Director of Nursing advised my manager, the co-director, to inform me that I was no longer necessary to attend the Director of Nursing meeting, and that my colleague in mental health would attend on behalf of learning disability and bring the information back to myself. 11:45 11:45 11:46

It wasn't in any way about having a pay increase or anything like that that annoyed me, it was the fact that learning disability was being lumped in with the same as mental health. 11:46

Well, there was two things. I never was given the chance to apply, if you like, to be that lead, but it was more about not having my say for learning disability, and that, you know, the person who was my counterpart in mental health did feel the same; it was imposed on himself without consideration, although we worked very well together. 11:46

PROFESSOR MURPHY: So what you're saying is that you

felt learning disabilities was getting subsumed under mental health in a way it hadn't been before?

A. Absolutely.

PROFESSOR MURPHY: Am I understanding you right.

A. Yes. Absolutely. 11:47

CHAIRPERSON: Can you just help me. Who would have attended those meetings then?

A. It would have been, say -- it could have been somebody, I imagine - I'm saying I imagine, I'm not sure - I imagine it would be surgical medical -- 11:47

CHAIRPERSON: You weren't there.

A. -- you know, because I wasn't there. But I was told no, it would be two -- not, it would be -- there was no negotiations on it. Actually the comment came back, it came back to me to say I could have a 10% pay rise of 11:47 the next grade but I still wouldn't be going to the meetings, but that wasn't what I wanted. I wanted to be --

CHAIRPERSON: No, I understand that. I just wanted to understand if you had have been in attendance, who 11:47 would you have expected to meet there?

A. I would have expected to meet my colleague in mental health and maybe somebody managing emergency care and...

CHAIRPERSON: From other hospitals? 11:47

A. Yeah. Within the Belfast Trust, yes.

CHAIRPERSON: Exactly.

DR. MAXWELL: So was the decision that there would be one senior nurse from each directorate?

A. Yes.

DR. MAXWELL: So in some of the other directorates, there might have been other nurses aggrieved that their particular speciality wasn't there. So, from surgery they might have been represented by somebody from ENT or somebody from ophthalmology or somebody from general surgery, they wouldn't all have been there? 11:48

A. They may have been but I still feel that learning disability was special.

DR. MAXWELL: I understand your point but I'm trying to think of a reason -- 11:48

A. Yes, that was exactly the --

DR. MAXWELL: -- one senior nurse from each directorate.

A. That was exactly the rationale. 11:48

99 Q. MR. McEVOY: And you give an illustration then of the out working of that for you. You say how, at 193, in relation to infection control and flu', you would have been included in professional discussions previously but no longer had that role, which meant that a Trust-wide strategy was created without the perspective of a learning disability nurse. Therefore, you expressed the views that patients with learning disabilities were not considered as well as they should have been. You also received your clinical supervision from that other -- 11:48 11:49

A. Yeah.

100 Q. -- is that the co-director; have I got it the right way?

A. No, he would have been a service manager.
101 Q. A service manager. What was personally uncomfortable about that?
A. He didn't feel that he -- the issues and maybe some of the literature on learning disability, he didn't feel he was expert in learning disability to be advising on some of the clinical supervision issues. 11:49
102 Q. And this was something you both recognised?
A. Yes. And I would have felt the same on mental health.
DR. MAXWELL: So was there are a more senior learning disability nurse than you in the Trust? 11:49
A. No.
DR. MAXWELL: So who would you have been comfortable having clinical supervision with?
A. I suppose I would have thought maybe one of the co-directors -- 11:50
DR. MAXWELL: Would that --
A. -- of the Trust.
DR. MAXWELL: -- have been a learning disability nurse?
A. No, there wouldn't have been, but... No, there wouldn't have been. 11:50
DR. MAXWELL: Okay. Thank you.
MR. McEVOY: At 194 you say you never had to complain about a co-director but you say that if you think if you had to complain about one, it was uncomfortable for you to continue on a day-to-day basis due to the way in which H730 worked. You say that had you not been retiring when you were, you might have found later working with H730 would have been challenging; his 11:50

management style struck you as one uninterested in change or innovation, and would prefer not to rock the boat and continue with everything as is. You give an example of a meeting at Fairview and the topic of the Equal Lives strategy came up, and H730 asked what Equal Lives was and it was shocking to those at the meeting. 11:51

Had H730, from your recollection, any background or expertise in learning disability?

A. No. 11:51

103 Q. Okay. Moving forward then to page 57 and it's paragraph 202. Here we come on to the topic of CCTV at Muckamore and what you can remember about it. You remember there being a CCTV around the perimeter and around the entrances and exits of the new wards. You 11:52 remember this being necessary for a range of reasons during the course of your career. So, protection of staff and patients from the threat from paramilitaries; the protection and staff and patients from the risk of irate relatives; and the protection of patients, and 11:52 particularly newly detained patients, from the risk of absconding, and then, of course, the protection of patients who were either themselves or their families on the edges of criminality or under threat from criminals. 11:52

Then you describe how there was recording equipment in the observation room in Cranfield Ward which was used therapeutically for analysing family dynamics. This

was subject to strict guidelines and it was always done with the knowledge of the families following clearance with the clinical team. There was also some recording done for training purposes.

11:53

Can you just help us to understand in relation to its use therapeutically, what that might have entailed? If you can give us an example just to understand.

A. Yes. It could have been somebody maybe who was receiving counselling or psychotherapy. 11:53

104 Q. Yes.

A. And it could have been maybe with a trainee and there would have been a supervisor watching, supervising, for example. Or it could have been it was used within the guidelines of the Adapted Sex Offender Programme. 11:53

105 Q. Okay. You refer to strict guidelines; can you recall what guidelines you're referring to there?

A. It was guidelines around who was watching; what was done with the recording; consent.

106 Q. Okay. Whose were they? Were they a Trust document or 11:54 were they drawn up by staff?

A. That was a -- I'm sure it was a hospital document or an operational document for the...

107 Q. You don't recall whether they had a name as such, a title as such? 11:54

A. No.

108 Q. It's a long time ago, sorry.

A. No, I don't, other than it would be use of the observation. But I would be pretty certain it was

within the Cranfield operational policy.

109 Q. Okay. Thank you. In the next paragraph then you tell us that there wasn't, during the course of your career, any internal CCTV within the hospital. As part of the design of the new units, you worked with other members of senior management such as the Clinical Director and business manager, and consideration was given to its introduction within the hospital buildings. You gained understanding and awareness of how it was used in other LD units from your own knowledge and experience and from visiting other facilities and units as part of the process. You recall visiting other facilities in Great Britain in relation to the use of CCTV. You recollect that there was no-one within the hospital who was pro CCTV use, and indeed you recall that there was significant resistance expressed by psychiatrists to its wider use. You have summarised those as follows: The potential impact on patients who were admitted who were unwell with aspects of paranoia or delusion. Secondly then, concerns about how to respect patient dignity given the disinhibited nature of some of the patients behaviours, meaning they would be removing clothing, and that that would be respected. 11:54 11:55 11:55 11:55

You then recall how you were made aware by psychiatrists at the hospital that the regulatory body, the Royal College of Psychiatrists, had concerns about patient awareness of the cameras which could have increased their paranoia, and there was a concern that 11:56

patients could potentially end up sitting up watching cameras and that would not have assisted either their treatment or their recovery. You refer to annual training audits of the hospital performed by the Royal College of Psychiatrists. 11:56

In terms of those audits, do you remember either the audits or those concerns being discussed at management level?

A. It came back under the discussion within the plan, the business case. 11:56

110 Q. It would have fed into that process?

A. Yes. It would have fed into that process, that business case, yes. Mhm-mhm.

111 Q. You then go on and tell us that there was consensus that certain areas of the hospital definitely should haven't CCTVs, bathroom and bedrooms. You recall a lot of staff expressing concerns all centered on patient dignity; none related to staff issues. You recall some discussions between staff, although you don't recall names, about whether CCTV without sound was enough as it would only amount to a snapshot without the additional context of audio. You recall someone exploring the view that CCTV would benefit the hospital as it would assist in defending against staff personal injury claims, although you don't recall who that was and you didn't think it was a particular issue. 11:57 11:57

You then go on and say that you didn't anticipate that

CCTV would detect staff wrongdoing or misconduct, and you don't know of comparable hospitals or units which had it. You didn't understand the benefit of CCTV or how we could develop a system where it was viewed correctly, and what value it would bring to patient care. You didn't feel it was necessary. You had a concern about its impact on patient care which you think might have been overlooked by many. In other words, your concern was that the introduction of CCTV would result in senior nurses supervising from their offices off the wards so that they could remotely monitor staff performance. The office is a central part of the ward but the presence of the Ward Manager on the ward is vital, and it is the insurance that ward tasks which are supposed to essentially get done get done, and that staff do not become complacent and simply watch the world go by with patients. Effectively then what you go on then and say is that your concern was that CCTV might have inhibited that. 11:58 11:58 11:58

Was thought given, although you have expressed that concern and articulated the basis for it, by you or by others as to how that CCTV was to be introduced, how that risk that you've identified of staff, for example, sitting in the office remotely doing their supervisory tasks, whether that could have been governed by specific protocols or policies? 11:58 11:59

A. No, to be honest, I don't think that it was because the consensus was that it wouldn't -- it wasn't suitable.

It wouldn't be, you know... It never really was a proper consideration that you would put it in and then monitor how staff were doing their job.

112 Q. So there was no part of the process where you were thinking, well, look, if we do bring in CCTV, there are possibilities, there are ways in which it might help the job -- 11:59

A. Yeah.

113 Q. -- there are some risks associated with it and that risk, as with any risk I suppose, could be addressed by the use of a policy or protocol? 12:00

A. Yeah. No. It wasn't seriously considered after what I've already described are the reasons for it.

114 Q. Okay. Then you go on at paragraph 209, which is over on page 60, to give us your recollection about the design of the new facility in the hospital. One of the things that you recall is a reduction from 87 beds, which included psychiatry and psychology beds, to 35, to include forensic patients. You remember there being consensus about that decision. 12:00 12:00

Can you help us understand when that decision was arrived at, and what the basis for the numbers was?

A. No, sorry, I couldn't, and I couldn't direct you to where it's actually written down. 12:01

115 Q. Yes.

A. But what I can say is that on regional discussions with other Trusts and with -- you know, through regional resettlement through planning, it was the hope, I

think, that as the services would develop in the other community Trusts, that these were the beds that were needed now but if everybody else's plan came to be, we could reduce down and be a regional facility. There was definitely a lot of talk about a regional facility for forensic patients and maybe for the more ill patients who required the like of the Intensive Care Unit. And that if -- so it was something that was in the -- you know, it was 87 beds but there was definitely thinking around the long-term, it could be 10, 15 years, you could actually reduce down, depending on how quickly the growth happened within the community. 12:01 12:02

116 Q. So there were a number of factors in the equation?

A. Yes. It was a wish and a dream but something that people, I think, at that time felt could happen. 12:02

117 Q. So, where did the number 35 come from then?

A. I think it was just -- that was just based on the other Trusts, the plans, what they had plans in their business case, or were hoping to deliver in their local services, which would have included possibly emergency assessment treatment beds within community units or respite units. 12:02

118 Q. Okay. In the succeeding paragraphs, the following paragraphs then you talk about -- you go back and talk about seclusion again. We've touched on it and we've certainly touched on its historical use. To pick up at paragraph 217 on page 61, you give a description of past incidents where you witnessed and were involved in 12:03

managing incidents where a staff member was accused of being aggressive with a patient. You go on to describe those and the process that would have been followed.

When roughly, for the Inquiry's benefit, are you talking about when you describe this period? 12:03

A. Probably in or around the mid 80s.

119 Q. Okay.

A. 80s, 80s to 90s, you know.

120 Q. So we could say then at paragraph 218 then -- 12:04

A. Even beyond. Probably right -- sorry, excuse me. Probably right up until the Vulnerable Adult Policy, you know, came in. I think the point I am making there is the management of something that happened was a decision that was taken nurse in charge, duty officer 12:04 internally within the management structure. Then once it came to 2007 and the Vulnerable Adult Policy came in, that changed.

121 Q. So the process that is described in 218 then that you've described to immediately remove the member of 12:04 staff, get the patient the medical treatment required, nurse in charge, duty officer, medical officer all to be notified immediately, investigating officer would do a quick report to you and liaise with other parties, and then the member of staff would have been suspended 12:05 if there was any hint that what had been alleged had occurred, so that's a process up until 2007?

A. It actually would have -- that would have been the process, when I think about it, after 2007 as well,

except that the decision, you know, the initial removal of the staff from the area or the discussion around the need to suspend the staff or whatever would have been -- would have been then referred to or taken by the Vulnerable Adult Officer.

122 Q. As opposed to the Ward Manager?

A. As opposed to the Ward Manager or the senior nurse or myself, because there would have been discussion with - I can't actually recall the name of the person - the investigating officer, who would have been linking in with the Police Service of Northern Ireland depending on the severity of the thing.

DR. MAXWELL: In what profession would the investigating officer have been?

A. Social work.

DR. MAXWELL: So even before 2007, the social workers would have done the investigation?

A. No. Before that, it would have been the nursing, it would have been the nurse managers that would have done the investigation. Some of the senior nurse managers, the senior nurse managers would all have been trained up under Vulnerable Adult to be investigating officers, but they only covered out-of-hours or weekends and it was handed over to social work on the next working day.

DR. MAXWELL: So one of the big changes in 2007 was the investigation was done by social workers?

A. Yes.

DR. MAXWELL: As well as the subsequent discussion?

A. Yes. But the protocol, the safety of the patient and

the gathering of information would still have been the same. It was just the...

DR. MAXWELL: Yes.

CHAIRPERSON: Can I just ask, the process that you are describing in paragraph 218, how quickly would all of this be accomplished? You said the investigating officer would do a quick report for you; what does that mean? 12:07

A. Oh, within hours. If something -- if somebody had reported that somebody had been aggressive or hit somebody or, say, had struck somebody, that would have immediately I'd picked -- then there would have been a phone call happened, the person would have been removed. That would have been within a very short space of time. 12:07

CHAIRPERSON: Within hours?

A. Yes, absolutely.

123 Q. MR. McEVOY: Before the 2007 policy on vulnerable adults was implemented, was there a similar policy that it replaced? 12:08

A. Yes, there was a policy. There was a policy around -- I can't remember the title of the policy but there was absolutely a policy around investigating untoward incidents.

124 Q. Okay. 12:08

DR. MAXWELL: So that was under the untoward incidents rather than specifically vulnerable people?

A. Yes.

125 Q. MR. McEVOY: So the shift was in the focus of the --

A. Yes, absolutely. Yeah.
DR. MAXWELL: Sorry, can I just add to that because this has come up in other parts of the Inquiry. If there was an allegation that a member of staff had been aggressive to a patient, would that be treated as both a vulnerable adult investigation and an untoward incident? Would you have filled in an incident form as well as? 12:08
A. Your form would have been your incident form because there was no vulnerable adult form prior to.
DR. MAXWELL: But was there not a special form from 2007? 12:08
A. Oh, yes, from 2007 there would have been two.
DR. MAXWELL: So from 2007, would you fill in an incident form and so it would go through the untoward incidents governance process, and also do the vulnerable adults process? 12:08
A. Yes.
DR. MAXWELL: So you would have two ways of reporting it. 12:09
A. Yes. Yes. Because the comment, the sign-off for the untoward incident would have said referred to VA1 and the process had gone on.
126 Q. MR. McEVOY: Turning over to page 69 and it's paragraph 255. This is where you're talking about staff members themselves sustaining an injury, and you say that this would have been a trigger for you to investigate further to ascertain what was happening on the ward and with the patients, and you would have attended the ward 12:09

if possible to satisfy yourself that all was in order.

What period of time are we talking about here when that would have been your approach?

A. Well, obviously the staff member being injured, that would have been a serious injury that I'm talking about on this occasion because there would have been multiple injuries every day. If it had -- there were some very serious incidents and I would have tried to have -- obviously, the duty officer, the Senior Nurse Manager would have been on the scene and been part of probably getting the staff member attended to or home et cetera. But I would have tried to have gone onto the ward either that day or the next day, within 24 hours of it happening because to just, as I say, satisfy myself that every -- you know, that everybody else was okay and to establish what the ultimate cause was because maybe the patient needed extra supervision, or maybe there was something else that needed to be done, like move the patient to another ward. 12:10 12:10 12:10 12:11

127 Q. In the following paragraphs, you talk about the kind of steps that you might have looked at. If the police had been required, who would you have contacted; in other words Ms. Connolly and Ms. Somerville. You would have attended the incident, and also asked the medical officer to attend. You might have looked at Occupational Health referral for injured staff members into the Trust Occupational Health service. 12:11

A. Yes.

128 Q. And you would also maybe have sign-posted injured staff members to the staff support group, or counselling services available to staff members.

Where those types of incidents had occurred, was there an opportunity to take the lessons learned and feed them back in and look at whether alterations needed to be made to policy and practice? 12:11

A. Well yes. It depended on -- as I say, it depended on the severity of the incident but if it was something that hadn't occurred before, for instance it could have been a patient that was admitted that was concealing something that made an attempt to stab a staff or poke an eye or something, that would have been back to looking at, for instance, the search policy, did we need a search policy; were there different... How we actually, say, nurse patients in certain areas, there would definitely have been an analysis of what post event happened and a follow-on from that. But it depended very much on the injury. 12:12 12:12

129 Q. I know it's hard to sort of talk about hypotheticals but I guess in the kind of courses of action you've outlined there, it's all focused towards the staff member - understandably, of course - but I'm thinking about what consideration in parallel might have been had towards the patient in question, and whether or not the incident that had led to the injury had its cause in some stressor for the patient that might have triggered it? 12:13

A. Yes. That would have been all part of the initial -- the report that the reporting officer had compiled leading up to what had happened, and again of course there would have been followed up. That's why the medical staff and all would have been, you know, informed as well when there was a staff injury. The patient quite often at that stage maybe needed PRN medication, or it could have been toothache, it could have been something else that was triggering. That would have been part of what would have been expected to have been in the accompanying report. 12:13 12:13

And it was very important that that was included because especially if it was leading maybe to a claim or, you know... We had to have all that information very clear as well. 12:14

130 Q. Quite aside from the question of claims, if there was a sort of situation on a ward where a patient was being stressed out by a certain behaviour might have reacted with the consequence of a staff member being injured, presumably that was something that was -- 12:14

A. Oh, yes. We would have looked obviously at triggers; was there something that the staff had done, was there a conflict, would definitely have been part of the analysis of what had happened, yes. 12:14

131 Q. Then --

A. And sorry, can I just add in then I would have looked at -- one of the things we'd have looked at was the suitability of the member of staff for the area, and

their training history.

132 Q. Looking across to - it begins on page 74 paragraph 285 - I am going to summarise some paragraphs about monitoring, visiting by other organisations and bodies. At 285 on page 74, you talk about your recollection of visits from the Mental Health Commission. You recall visits around twice a year and further unannounced visits. You understood that they had a key role in the monitoring of detention, and they spoke to detained patients. Relatives were also informed and invited to meet with the commission. In addition, the hospital staff were invited to discussions with the commission. They would review and monitor detention forms, would have provided feedback if they weren't in order. The visits lasted a number of days and feedback would go to the senior management team and then filtered back to us. 12:15 12:15 12:15

"The commission was informed by someone senior at the hospital if there was an issue of concern which had been raised by us with the senior management team." 12:15

You recall one particular incident were a patient had self-harmed herself, and the commission, and indeed the Health and Safety Executive, were informed. 12:16

You say that the visits of the commission were seen as very important. You then recollect how it was replaced by the RQIA in 2009. You don't recall any particular

issue flagged by the RQIA during your time, but they were only in existence for two and a half years prior to your retirement. You do, however, recall having meetings with them, and their inspections. You recall lots of correspondence with them and a real focus on standards. You recall that the RQIA had specific officers for learning disability and that they made themselves available for patients and families. You recall that the RQIA also did both announced and unannounced visits, and you felt that they were approachable. The reports, you say, should be available. Some of the people working for RQIA had previously worked for the Mental Health Commission. 12:16 12:16

You recall some of the early RQIA work with the hospital that you were involved with, there was a focus on compliance, standards, care planning and records. The RQIA did have some follow-up at the hospital and with you in relation to delayed discharges. While the RQIA can issue things such Improvement Orders or Closure Orders, you do not recall anything like that during your time. 12:17 12:17

In relation, finally, just to that point about delayed discharges, can you recall how those discussions and follow-up would have resolved itself with the RQIA? 12:17

A. Not in my time because there was still a large number of delayed discharges.

133 Q. Yes.

A. It was just something that they were aware of, and I know it was being considered within...

134 Q. These are sort of ongoing cases as such?

A. Yes. Yes. Yes. Yes.

DR. MAXWELL: Can I ask, would RQIA have made a determination about whether the delay was due to shortcomings at MAH or whether it was due to wider system failures? 12:18

A. I think by the time it was still probably too early in its organisation to -- it was just, you know. 12:18

DR. MAXWELL: Just noting it.

A. Noted, and I assume they had discussions with the Department and other people. But there was nothing -- they weren't sort of actively doing it, as I recall.

DR. MAXWELL: Okay. Thank you. 12:18

135 Q. MR. McEVOY: Okay. You then go on to describe how the Royal College of Psychiatrists, which we touched on in relation to the CCTV issue, was another method of monitoring the hospital. You were able to raise issues and feed back to it. It was the training and regulatory body for psychiatrists - overleaf now on page 76 - and visited the hospital once per year. The visits lasted for one or two days, and the inspecting doctors would have spoken to the nurses in charge of a number of wards and asked them about, and you have listed about a number of factors there. Topics: Levels of supervision; treatment available to patients; quality of training; availability of research time; availability or non-availability of duty officers, and 12:18 12:19

resourcing.

You describe how the presence of the Royal College in the hospital was significant for a number of reasons. The hospital was a teaching hospital to they expected to see a very clear training plan, and to see research. 12:19
The college was a powerful body. The bulk of psychiatrists in Northern Ireland were based in Muckamore, albeit that they did outreach work as well. The views of the feedback from the Royal College was valued at Trust level, and they were responsible for 12:19
the commissioning of services for patients in their area. The Northern and the Eastern Trusts were the main commissioning Trusts for the hospital; Western and Southern Trusts only had a few beds at each and they had different arrangements available for patients in 12:20
their Trust areas.

The Royal College, you recollect, looked at the patient's entire psychiatric needs, not just their LD needs. In relation to each section of the hospital, 12:20
you recall that the Royal College wanted to see clear training for all members of staff according to the patients with whom they were dealing, wanting to see evidence of your forensic training and rehabilitation of children training, for example, but you're not sure 12:20
whether they looked at complaints from patients or the discipline of staff.

You don't recall that the Royal College raised any

concerns about any aspect of care at the hospital. "There may have been issues that they highlight in their reports that could we could have improved upon." The reports were provided to senior management at the hospital. 12:20

Now, when the Royal College visited, was that focusing on patient care or were they more focused on the role and training of psychiatrists? Was it something in between? 12:21

A. I'd say the role of the trainee was their main focus, but obviously the care, or if there were issues raised by the trainees.

136 Q. Yes.

A. For instance that was maybe impeding them in their training, that might have sort of been more to do with some of the structures or the ward, they would have come in on that. For instance, if the trainee was being duty doctor too often or, you know. 12:21

137 Q. I know you say they didn't raise concerns that you can recollect about any aspect of care at the hospital, but might they have raised with you any nursing issue that might have been impeding or affecting their trainees or members? 12:21

A. I can't recall but I imagine, I assume, I think that's what would have come back if it had been the case that they weren't, but I don't actually recall any specific. 12:21

138 Q. Yes.

A. In my expectation, they would have if there had been.

DR. MAXWELL: Can I ask? So the Royal College of Psychiatrists has standards for in-patient learning disability units?

A. Yes. Yes.

DR. MAXWELL: Did they formally audit MAH against their standards? 12:22

A. Yes, they did. That actually would have come in through our quality. I think it's actually sort of called part of the EQC as well, that their standards were looked at as part of the overall Evaluating Quality of Care. 12:22

DR. MAXWELL: So potentially someone somewhere should have in the archives audits against the standards?

A. Yes, they should have.

DR. MAXWELL: Thank you. 12:22

139 Q. MR. McEVOY: Then you talk about external monitoring by Queen's, who delivered training to student nurses, and also specialist and postgrad to experienced nurses.

"Every ward at the hospital had an allocated clinical tutor as a point of contact and part of their role was to provide feedback to Queen's. Everyone involved in the training as well as the trainee nurses themselves had a copy of the syllabus. If the trainee was not getting the right experience, the ward could have lost its status as a training ward." 12:23 12:23

You recall then that there were three tutors at Queen's with whom you and the other senior nurse managers

liaised, and one of those tutors would actually have attended senior nurse manager meetings at the hospital. You would have liaised with them on issues such as work force planning, the closure of wards, learning opportunities, and any other issues you felt appropriate. You described the tutors as being very proactive and would not have been behind the door if they saw something they were not happy with, and they would have raised these issues with the nurse in charge. 12:23

The Inquiry has heard evidence how Queen's was closely involved, ensuring it was an appropriate place for trainees. Did that change at any time?

A. Not in my time. Not in my time. 12:24

140 Q. Okay. Then you go on to describe the visits of the Royal College of Nursing at various junctures. Then at 301, if I could take you to page 78, you talk about the role of the Health and Safety Executive which had powers of inspection. 12:24

"They only came in if invited to attend or if there was a particular issue they were required to attend. They had the power to carry out unannounced visits but they normally gave notice." 12:24

They provided you and others in the hospital with updates and alerts about issues at other similar facilities or hospitals.

You were involved or had awareness of the reporting of various issues to the HSE, which included adverse incidents patient safety issues, any incident which resulted in a staff absence of greater than three days, and any other serious incident. You then go on to describe how, in 2006, the HSE became involved in the investigation into seclusion at the hospital. This was triggered by an investigation and coverage by the MBEC Northern Ireland health correspondence, Dot Kirby. 12:25

Can you tell us a bit more about the investigation that the HSE carried out in 2006 following that report?

A. Yes. The issue had been raised by a visitor to the hospital, who had raised an issue about a patient being in the Fintona; Fintona was built around an internal courtyard. And whilst she was visiting her friend in the hospital, she became aware of a patient in the courtyard who was walking about and crying and "let me in", and it appeared that the patient had been locked in this courtyard. So the person brought the complaint to the correspondent and that led to an investigation into that, and also then broadened out into the use of seclusion, the use of the courtyard, unlocked seclusion. 12:25 12:26 12:26

So as part of that, the Health and Safety Executive came in and, for instance, measured the spaces and looked at temperatures and did all sorts of things

around the whole seclusion room and the safety of the internal courtyard should somebody be wanting to take themselves off out to it to let off steam.

141 Q. Can you remember what the outcome of the Executive's investigation was; the implications were, if any, for the hospital? 12:27

A. There wasn't -- I don't recall if there was anything specifically from the HSE, but I do recall that there was a policy review and that any patient who was taking time out in the internal courtyard had to be docu -- well, it was maybe documented in a care plan in their notes, but there was actually somebody then observing and completing an observation chart and making a record of the patient. 12:27

DR. MAXWELL: Can I just ask about that incident because you describe it as time out, which sounds as though the patient wants time out. But what is described to us was a patient crying and saying "let me in", which sounds as though the patient wasn't asking for time out? 12:27

A. Yeah. That was the -- that was the complaint that was what the incident was. From memory, I don't think it was ever proven whether that she... From my memory the incident was that the patient could come in but wasn't coming in but was making a "let me in" but, you know, wasn't. We were never able to prove whether she was locked out or not locked out on that occasion. 12:28

DR. MAXWELL: Okay. So it was unclear whether she was able to come back in or not?

A. Yeah, yeah. But there was a policy review immediately after that that recorded even if somebody was out and not locked out, that it was observed and recorded.

DR. MAXWELL: Thank you.

142 Q. MR. McEVOY: In the next paragraph you say that you recall the HSE being involved in the points of ligature investigation. Is that something you were involved in yourself? 12:28

A. No. Well, no, I wasn't in the... Well, yes and no. I wasn't in the senior position at that stage, I was still a ward sister, but the points of ligature happened then on every ward. There was funding, for instance, for boxing-in toilet cisterns and changing curtain rails. So it affected every ward, so every Ward Manager would have had follow-on. 12:28 12:29

143 Q. When was that, do you recollect?

A. Early 90s, from memory.

144 Q. Okay. Paragraph 306 then, you describe your involvement, as far as you can remember, with the patient and client counsel, the PCC? 12:29

A. Yes.

145 Q. It was newer than the organisations with input into the hospital. It had some advocacy roles in relation to patients. You met with them in relation to a number of patient issues and complaints; most of these you recall regarding resettlement. You were involved in the hospital response to a complaint which came regarding -- which came via the PCC regarding a patient on Fairview around 2010. Fairview was reduced in 12:29

patient numbers from 20 to eight or nine patients. This was a resettlement ward, and Miriam Somerville and you received a Trust level order to close the ward. Miriam and you were able to locate a number of beds on Ennis Ward... 12:30

"But we only had two weeks to move the patients and that was done without engagement with the families. It was very different to how we had worked in the past but it was for acute financial reasons. I think the PCC", 12:30
you go on and say, "and families were correct to raise the issue, albeit we were right to take the steps we did from a corporate perspective and it was a purely financial division based on the consideration of cost centres." 12:30

Thinking back on that situation and the resultant complaint, was it pointed out when the order came from the Trust to close the ward that it would mean, or one consequence of having to do it so quickly, would mean 12:31
there would be implications for your ability to communicate with families about it?

A. Yes.

146 Q. And what was the response?

A. It was non-negotiable. 12:31

147 Q. Yes.

A. And it would have been beds in Greenan and Ennis.

148 Q. Yes.

A. I can add that the consultation with the families was

in the form of the Ward Sister letting them know that the ward was closing in two weeks.

149 Q. Yes, okay. The use of the phrase in paragraph 307, having made the point that the PCC and families were correct to raise the issue, you were right to take the steps you did from a corporate perspective, can you tell us what you mean by that? 12:31

A. Well, I suppose I mean, yeah, money is tight, there's a bed sitting, there's a room -- sorry, a ward with eight or nine patients and there's maybe 12 beds available in other wards, so based on the notion that you can move patients there, you know, it was -- I would say that from definitely from my own point of view, I didn't -- I wasn't able to win an argument to say we need more time, we need more. It was this has to be done. 12:32 12:32

CHAIRPERSON: But it sounds quite different to what you described earlier.

A. Absolutely. It was a total change of how we would have done things. Previously there would have been a -- families would have been informed. Patients obviously who could understand would be informed, families would have been informed that we were going to do this. I don't recall any big issue in the previous way we did it, and families would have understood that, you know, we negotiated that people were moving with their friends and with staff and got to see the new ward they were going to et cetera, but we didn't have the time with this. 12:32 12:32

CHAIRPERSON: And would you say the same consideration was given to the patient welfare as it had been before?

A. I -- I don't think so. I really don't believe they did so, and I would actually go as far to say it was probably the final step for myself to consider retirement because it just had a different approach to how we were going to be managing.

CHAIRPERSON: Because of the way this was done --

A. Yes.

CHAIRPERSON: -- and the way the patients were treated? 12:33

A. We are now in this save money, do this, there's beds there, it's not, you know... And the feedback from the particular family who raised the concern with the PCC, and myself and the Clinical Director had to meet with the family and try and justify something that I didn't believe in myself, was difficult. 12:34

CHAIRPERSON: Did you raise your concerns with those above you?

A. Yes, as far as I could but there was -- I hadn't the same line up to the Trust Board that would I have had in the North and West Belfast. 12:34

PROFESSOR MURPHY: How did it save that much money given that, you know, the staff presumably would have moved over with the patients to Ennis? So what would it have saved; heating? 12:34

A. It would -- yes, basically. Basically it would have been the heating and lighting on the ward.

DR. MAXWELL: But that is a tiny cost compared to salaries, isn't it, so I'm just wondering why they were

in such a panic about such a small cost?

A. I can't answer that.

150 Q. MR. McEVOY: If you look at page 82, please, and it is the bottom paragraph, 327. A slightly different topic now which is around the role of the Duty Officer. This you describe as being an important role and dealt with day-to-day queries and issues. It was filled by a Band 7 nurse during the day, a Band 7 and then re-graded to Band 6 at night-time. There were two night duty officers. Then you go on and describe how they would have contacted via the bleeper or there would have been an untoward incident or accident, and how they would have reported to you on the things listed in 328: Staff sickness; staff who hadn't turned up for duty; discharges; staff or patient falls; incidents and injuries; seclusion of a patient; bouts of patient vomiting or illness; missing patients or attempts to abscond; complaints from patients or family members; patient transfer to the local hospital for medical treatment, and other serious issues such as the activation of fire alarms. 12:35 12:35 12:36 12:36

Can you recall when that duty officer role started?

A. It was always there from whenever I first came, there was always one nominated Duty Officer. When it had been the two male, female sides to the hospital, they would have put each one but it was always there. 12:36

151 Q. And was it still in place when you retired?

A. It was in place when I retired.

152 Q. And to your knowledge, do you know is it still going today?

A. It's not.

153 Q. It's not?

A. It's not. 12:36

154 Q. Do you know when it was done away with? I know you've been retired for some years now.

A. I have been retired for some time. Certainly I couldn't be certain, but before the current investigations into the hospital started. 12:37

DR. MAXWELL: But it was still in place when you retired?

A. It was in post when I retired.

155 Q. MR. McEVOY: Sometime pre-2017, you think, possibly?

A. Yes. As such as being dedicated, but I mean it is unfair really of me to comment beyond that -- 12:37

156 Q. Of course. No. No?

A. Because I don't really know. But I know the role of the nursing officer in the admin building and that changed after I retired. 12:37

CHAIRPERSON: But did somebody take over the same, maybe not a Duty Officer; do you know?

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

DR. MAXWELL: But this was a person allocated each day? It could differ, there wasn't a -- it was just a duty. 12:37

A. Yes, yes. My understanding is it maybe became a role of a ward manager on top of their own duties as opposed to a distinct person, that that was your duty for the day or your shift.

DR. MAXWELL: And on the bleep?

A. Yes.

157 Q. MR. McEVOY: Can I ask you then about what you've set out at page 84, and it starts about paragraph 336. It deals with the topic of the administration of pro re nata, or PRN medication. The Inquiry has heard quite a bit about the topic of PRN, as I'm sure you either know or appreciate, and how it was part of care, a you say, of current treatment of patients prone to outbursts, and you say that, during your time at the hospital, where a patient was triggered in some way and became aggressive or were at risk of injuring themselves or others. You then go on and describe a set of criteria that you applied and required staff to apply. You go on to say how you would have required staff to effectively stipulate in writing in care plans what triggers caused the individual patient to become severely agitated, when to administer it, and what medication to administer, what dosage and what, if any, extra sedation could be given, either Diazepam or other medicines. 12:38 12:38 12:38 12:39

Then, at 339, you describe your requirements as you saw it in relation to the administration of PRN. So it shouldn't be used an a first response; it should be administered by registered nurse, either by tablet or by intramuscular injection. Then paperwork and any commentary showed reflection by staff on how they attempted to de-escalate the situation; the patient's 12:39

reactions and what factors were in the judgment of the staff to use it, and whether there are any patterns of nursing treatment of causes or triggers which could be addressed differently in future; that its use then was recorded in the care plan, prescription sheet and medical records. Staff members monitor patients following its administration for side effects and so on, noting them where required. Family members to be made aware of the arrangements for the administration of PRN, and where necessary that it be given to relatives. Everyone be made aware of guidelines for PRN, and any contraindications in conjunction then with the pharmacist. Its use to be recorded in day and night sheets, and then staff, on your request, creating reports in relation to its use, and that was useful for pharmacy. 12:39 12:40 12:40

There are points A to J there which I have sort of very, very briefly summarised in relation to the use of PRN. You're quite clear these were your requirements as a senior management figure. If there had been -- if you'd learned of deviation from any of those requirements, what would have happened? 12:40

A. Well, that would have been considered the same as an error in the administration of medication. 12:41

158 Q. Yes.

A. And the same approach would have been taken under that policy.

159 Q. Yes. And any deviation or any departing from those

requirements, I mean, how would you have viewed that?

A. As an error; as something that shouldn't. I mean why -- I can't understand why anybody would be giving PRN outside of the guidelines; I think they were clear enough. Also if somebody was -- I mean it probably doesn't even cover it there, if someone was getting regular PRN several times a day or for weeks, it would have been reviewed by the medical -- the multidisciplinary team, and an overhaul of medications that maybe something became a permanent medication rather than a PRN. 12:41

160 Q. So, a constant or frequent resort to it is something that would have been flagged essentially?

A. Yes. Absolutely, yes, yes. And it's actually something as well that the pharmacist would have -- as well as particularly doctors in training that would have been doing regular audits, so would the pharmacist. 12:42

DR. MAXWELL: Would these PRN sedation have been on the duty sheet that went to the nursing office? 12:42

A. It would have been recorded, yes, on the report that PRN was given.

DR. MAXWELL: So the duty nurse --

A. Yes.

DR. MAXWELL: -- would know that one patient or one ward were frequent administrations? 12:42

A. Yes, yes. That's something that we would have picked up on.

DR. MAXWELL: Given that there is a different duty

nurse on each shift, did you or anybody else review those duty sheets on a weekly basis to look for trends?

A. Yes. It would have been -- so the Duty Officer, the duty nurse, the night officer, completed a synopsis of the activities of the day and that would have included PRN medication. I would -- that report would have been brought to myself on the next working day. You would have -- it was a small enough number in the nursing office, and that book was there to pick up. If somebody who was continually needing PRN, that was a pattern easily enough to identify. Also, one of the things that I would have expected people to look at was their particular staff who were having to administer PRN more than others. 12:43 12:43

DR. MAXWELL: So you would be confident when you were the most senior nurse in the hospital that you would have been well aware about the use of PRN? 12:43

A. I was.

DR. MAXWELL: Which patients, and indeed which staff, were administering it? 12:44

A. Yes.

DR. MAXWELL: Did the duty reports continue being used right up until your retirement?

A. No. Before I retired we were moving onto the Datix, to the PARIS. 12:44

DR. MAXWELL: To PARIS?

A. Yes. It was much more difficult to pick up. That was maybe just me. When I was there, I was still expecting people to do -- to highlight areas, but I could see the

like of PRN is something that could have just been... I would have to have went searching every ward's report.

DR. MAXWELL: So when the day and night reports stopped and records went on to PARIS, how would you, as the senior nurse in the hospital, have been able to search for that information? Would it have been possible in PARIS for you to search for that? 12:44

A. Just by going on to every ward and reading the reports.

DR. MAXWELL: But you couldn't get a summary; the system didn't allow you? 12:45

A. Not at that stage. It was still very new, it was still early days and I was still relying on the Duty Officer to write down the key points. But I could imagine that I wouldn't have been as confident they would all have been picked up. 12:45

DR. MAXWELL: Thank you.

A. To be brought to my attention, I mean.

CHAIRPERSON: So if there was consistently use of PRN or more, or if there was an increase in the use of PRN on a particular ward, it would have been much more difficult for you to see that? 12:45

A. Well, probably if it was significant, it would have been reported through as an incident or something that the Duty Officer would have been highlighting to me, you know. I mean, if it was a significant increase, that would have been coinciding with an increase of disturbed behaviour, you know, other patient issues. 12:46

CHAIRPERSON: It should have gone on to PARIS?

A. Yeah. Yeah.

CHAIRPERSON: Or Datix?

A. But when they brought me a synopsis, that would have triggered me to go onto the report for the ward to see. And it wasn't just me, obviously the medical doctors and consultants would have been picking up on this as well about the medication. But it would have to have been brought to my attention; it wasn't just as easy for me. 12:46

CHAIRPERSON: Well, quite. 12:46

A. Yeah.

PROFESSOR MURPHY: I can see what would happen if PRN for a particular patient was on upward trend, you know, it would have gone to the MDT meetings and had discussions that way. But when you say that you would also look to see which staff were needing to use PRN more, what would have happened in relation to that? What would you have done about that? 12:47

A. I would have been asking the Ward Manager to review the situation with the member of staff, you know, to draw to their attention, to delve down a wee bit more into what was happening. Particularly maybe at nights, say, when there's not so many around, what was happening, because night duty was particularly easy to monitor something like that, where, you know, if somebody was having to use more or be relying on PRN medication, or they were the staff that needed more help every night, or whatever, that would be the Ward Manager to deal with in supervision with the member of staff in the 12:47 12:47

first instance.

PROFESSOR MURPHY: And would that solve it, do you think, or were there consistent differences between staff?

A. I can't recall. There may have been times when that would have been a trigger for us to review the placement of certain staff on a certain ward, or for the person to maybe say, if they were on night duty, come on day duty if they were struggling. That would have been one aspect of it. If there was a very different pattern for how the patients were managed from one day or night to the other, that would have been one of the considerations that would have been looked at. 12:48 12:48

PROFESSOR MURPHY: Would you have sent them for extra training, for example? 12:48

A. That was one option that would have come out, possibly out of their supervision, of their training needs and maybe they needed a refresher in the administration of medication. Or indeed was there something else that was happening on another shift that people were doing differently that this other person didn't know, you know. It could have been something as simple as allowing somebody to sit up to 12 o'clock and watch TV, where somebody else was making them go to bed, you know. It would have been analysis of what was... But it would have been back down to Ward Manager level. 12:49 12:49

PROFESSOR MURPHY: Thank you.

CHAIRPERSON: Mr. McEvoy, how much longer have you got

to go?

MR. McEVOY: I was just signalling to the secretary there, half an hour, possibly 40 minutes.

CHAIRPERSON: All right. We obviously should break. Okay. I'm sorry, you are going to have to come back at 2:05, but we'll get you finished, as it were, as soon as we properly can. Okay. You will be looked after by the Inquiry staff and we will see you back at 2:05. Thank you very much. 12:49

12:50

THE HEARING RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Yes.

MR. McEVOY: Thank you Chair, thank you Panel. 13:57

161 Q. Mrs. Steele, could I ask you to turn then to page 90 and it's paragraph 364. In this paragraph you tell us about how you had a number of budgetary responsibilities in respect of nursing and day care and, as the hospital services manager, you were the professional lead of budgeting in the hospital. The day care budget was managed by H77 who reported to you, and you were the professional lead for community nursing and learning disability. You had a monthly meeting with the Co-Director of Finance as "I felt it was important to keep track of expenditure." 13:57 13:58

Within that role, did you have any responsibility for

the question of patient finances? I am thinking specifically about cash that might have been available to patients and staff for day-to-day purchases as necessary on the wards, that type of thing?

A. Yes, yes. As part of the policies for patients' finance, I would have been signing off on certain amounts of cash. There was a limit to what. The policy changed at various times, the amounts that we were allowed to sign off for, but if it was an above, I think £200 or something, the signature came to myself or the co-director of learning disability to sign off. 13:58 13:59

162 Q. Okay. The Inquiry has heard some evidence about issues that family members were encountering with patients' finances going missing --

A. Yeah. 13:59

163 Q. -- over the years. Were you ever aware of any such issues?

A. No, I was never aware of any issues of finance, of money going missing. I do recall some family members who maybe would have asked to have seen accounts or have been made aware of maybe if they'd -- if they had been asked. Some family members still claimed the benefits for the patients, and if they were being asked for money for events or for something, maybe would have queried what it was being used for, or maybe "I hadn't seen receipts." I can only remember one particular ward where it was brought to the attention of management after the charge nurse changed hands for to look into the expenditure of their son's money. There 13:59 14:00

was nothing untoward ever found but it was just a way of the query over some of the outings and the trips that they had had.

164 Q. Okay.

A. I don't recall anything -- well, the policy was there and it was very clear. If patients, if somebody had given in money, passed in money, there was a way of receipting that, they got a receipt from the ward, the money was to be lodged the next day at the cash office within Muckamore. There was also the provision of a night safe for out-of-hours deposits. 14:00 14:00

165 Q. And you don't recall any issue with receipting or anything of that nature?

A. Nothing that I was ever aware of.

166 Q. Okay. Moving down to the bottom of that page 368, casting your mind back to the days of the old North and West Trust as was, you recall that there was weekly meeting of the Chief Executive and directors of that Trust, and Muckamore was a standing item on the meeting agenda. Is that of the Board, of the Trust Board? 14:01 14:01

A. No, of the Chief Executive's meeting.

167 Q. Meeting, okay?

A. And then the Trust Board was every month. It would have been on the Trust Board as well but the Chief Executive's weekly meeting. 14:01

168 Q. Thanks for clarifying that. There was weekly and monthly meetings the Trust Board then over and above that?

A. Yes.

169 Q. Then you would have seen members of Muckamore -- of the Board rather, in Muckamore on a regular basis?
A. Yes.
170 Q. And you worked in the knowledge that they could visit at any moment? 14:02
A. Yeah.
171 Q. In addition to the hospital being a standing item on the Chief Executive's meeting, was it also a standing item on the Board's agenda?
A. Yes, I believe it was. I can't be certain but I believe it was fairly often. There were many Trust Board meetings actually held at Muckamore as well. 14:02
172 Q. Yeah?
A. But because when the Trust took it over, there were two many issues -- 14:02
173 Q. When you say the Trust, do you mean the new Belfast Trust?
A. Yes, the Belfast -- no, sorry, I mean North and West. When North and West took over, there was so many things had been raised maybe from like the Northern Ireland Hospital Advisory Service on the infrastructure. 14:02
That's just one example of what led to... And as well as that, the resettlement agenda. There were many items that were necessary for investment that it became, I think, very much a standing item. 14:03
174 Q. Okay. So there was always some Muckamore issue?
A. Yes.
175 Q. A Muckamore-related item on the agenda?
A. Yes. Yes.

176 Q. Do you know if there was or can you remember if there was a Board member on the old North and West Trust with specific responsibility for the hospital?

A. Yeah. Well, the director, the Director of Hospital and Community Learning Disability Services was the one with the responsibility for the hospital. Equally, and from a nursing point of view, the Director of Nursing had a responsibility as well. So I reported to one professionally and the other managerially. 14:03

177 Q. Okay. 14:03

DR. MAXWELL: Excuse me, were they voting members of the Board?

A. No. The Director of Nursing would have been the Executive.

DR. MAXWELL: So the Director of Nursing was the voting member of the Board, and the Director of Hospital and Community Learning Disability Services, who did they report to? 14:03

A. No, they were Chief Executive. They were on the Board as well, yes. Sorry, yes. 14:04

DR. MAXWELL: Yes, thank you.

178 Q. MR. McEVOY: Taking what you said at paragraph 370 about Mr. Black, who was the Chief Executive of the North and West Belfast Trust, he had an office at the hospital and worked there some days each week, he attended the meeting, the weekly Chief Executive meeting that was attended by your line manager. You put that on one hand then, there seems to be a contrast then in what you say overleaf in paragraph 376 on the 14:04

bottom of the next page, the second half of the next page. You contrast Mr. Black, who had an office there and held some meetings there. We then have a paragraph where you talk about how you heard that the Chief Executive of the new Belfast Trust, Mr. McKee, 2007. You recall having heard a comment which was attributed to him: "One thing, I want to close that place 15 miles of the road outside Antrim". Ms. Somerville was able to confirm that to you because she thinks she was at the meeting. 14:05

CHAIRPERSON: Of course, this is hearsay. It doesn't matter if you --

A. It was a phone call I had had from the professional, from the RCN professional staff, asking me about, you know, in the context of future plans from staffing. It was a query from staff following this comment. I think there had been representation from the union, from the RCN at this meeting. 14:05

CHAIRPERSON: So you obviously weren't there?

A. I wasn't aware of it. I wasn't at it; was not aware. 14:05

CHAIRPERSON: You heard of it how soon afterwards?

A. Yeah. Then when I asked Ms. Somerville about it, she confirmed it had been said.

179 Q. MR. McEVOY: So you heard it from this member of the nursing, one of the nursing union leaders? 14:06

A. Yes.

180 Q. And Mrs Somerville then confirmed it to you?

A. Yes.

181 Q. In terms of the contrast of that expression from

Mr. McKee and Mr. Black, I mean how did you make it feel? Contrast it with the approach of Mr. Black?

A. Disappointed because Mr. McKee had been out. One of his first visits was out to the hospital and appeared very enthusiastic about plans and what we were doing. So it sort, it was just a big disappointment that the respect wasn't there, I suppose, for what we did and what we were trying to do. 14:06

182 Q. Was there anything else about the approach more generally? Did it signal anything else more generally about the approach of the new Trust, in this period of time, towards the hospital, the period of time that you remained there? 14:07

A. Probably not initially accepting myself not attending the Director of Nursing meetings. Now I would have to say that I did attend meetings with the co-directors of nursing on various subjects, but that sort of had set a bad tone at the start. We were probably a bit suspicious then, I think, of what people were thinking. 14:07

183 Q. That sentiment, if I can use that way of describing it, about wanting to close the hospital the CEO had supposedly articulated, did you find that reflected in any other Board members? 14:07

A. Well, I couldn't say that I did because I honestly would have bother -- no. The director, the first Director of Nursing came down and did a shift on the wards and seemed enthusiastic about what we were doing. I have very little recall of any of the other Board Trust members from Belfast Trust actually visiting the 14:08

hospital.

184 Q. Then paragraph 377, you discuss raising risks outside of the hospital. You say you understood how to raise those risks and one of the risks that you did raise was around staffing and resourcing. Where staffing levels were below those required by patient care needs, you informed the Director of Nursing and the nursing officers and you spoke with members of the Board. You used your understanding and knowledge of the Telford Review tool to gather the required patient data to identify additional staffing requirements were patient behaviours - patients, I beg your pardoned - had behaviour or needs which required additional nursing time; collected the data and used it as the basis to request more funding to enable the required delivery of patient care. That was the main risk that you flagged externally? 14:08 14:09 14:09

A. Yes.

185 Q. When are we talking about?

A. That would have been, as I previously spoken about, particularly in the times of the North and West Belfast. But there would have been, again, discussion with the Associate Director of Nursing and the Belfast Trust, who was responsible for workforce. So it would have been the same model that we would have used for that. 14:09 14:09

186 Q. Okay.

DR. MAXWELL: Were these shortages in staffing or problems with staffing levels that you felt strongly

enough to raise outside the Directorate, were these issues the same across all your time at Muckamore, or were there periods of time when you were more concerned about staffing than others?

A. There was probably times it would have been issues maybe with enhanced supervision that was causing -- so the budget was so tight, the nursing budget was so tight, that if you were having to increase because of whatever was happening on the ward, the constant levels of supervision and particularly maybe the like of night duty, that we were going across or maybe needing to use overtime, those would have been issues. It was fairly -- it was very small numbers. 14:10 14:10

The workforce plan took into consideration the age profile of staff and who was likely to retire, the turnover. You know, I did find with both Trusts and with working with the Director and Associate Directors of Nursing that they did listen to, you know, the feeling that I would have had or known about the likely turnover of staff. I felt it was always really important to allow a bit of leeway and to also -- with the like of the children's unit, for example, had opened by this stage, by 2010, and Muckamore was still supplying staff for children's there. For example, a time when there had been a bit of trouble, political trouble in the area and there had to be enhanced staff go in, it would have been issues like that that we would have been raising as a cost pressure. 14:10 14:11 14:11

There was always -- there was always a reason not to be careful about the staff you would have, say, commissioned or let go on commissioned courses and planning carefully that way, that you didn't let too many staff just be seconded off to courses, that you had enough to do.

There was a lot of sort of planning for the next generation of senior staff nurses that would up and coming. That's how the training and sort of resource identifying who was interested in what and planning for ahead.

DR. MAXWELL: So you said there that sometimes the pressure was when you had to do additional supervision of patients on ward? 14:12

A. Yes.

DR. MAXWELL: When the budget was being set, was there recognition within that budget that there would be this need for additional nurses? 14:13

A. Yes, there was. That was a lot of work that was done in the early days of North and West. We would have produced data every month and presented it to the nursing officers at the Boards to build up a higher skill mix than we would have had in previous, when I would have taken over as hospital services manager. But the extra pressures I'm talking about would have been additional to that something that would have cropped up, and it was a way of reviewing the whole

budget.

DR. MAXWELL: So there is no flexibility in the budget, recognising there would be times when you needed more bodies as well as more skills?

A. Yes, there was but not -- it was incorporated into the main budget, so if anything else cropped up, there was very little leeway without going over. 14:13

DR. MAXWELL: Was there a difference in attitude to funding this flexibility when it moved from North-West Belfast to Belfast Trust? 14:14

A. No. I think it was -- I think it was still all right because it was the same finance officers that we were dealing with, you know, it was the same co-director of finance who was looking after that bit. As long as the evidence was presented in the same way, it was easy and clear to the colleagues that that was ... 14:14

DR. MAXWELL: As the hospital changed, as more people got resettled out, did the number of patients who needed supervision increase?

A. Sometimes it seemed that way. Not, I would say not. When we opened Cranfield and Killead and Donegore, I think we had it pretty nearly spot on because we had an enhanced budget then and we had enhanced skill mix. Maybe I'm not... 14:15

DR. MAXWELL: I'm actually about the patients rather than the staffing. 14:15

A. All right.

DR. MAXWELL: The nature of the patients, their needs. You talked about how you had a lot of patients who had

a lot of physical disabilities.

A. Yeah. Yeah.

DR. MAXWELL: The primary focus was on that. Did you now have a larger percentage of patients who needed supervision because of behavioural issues? 14:15

A. Yes, our admissions were different admissions. The admissions were coming in, they were more challenging behaviour, they had more behavioural needs. Therefore, even the layout of the new wards probably meant that you needed additional staff, but that was built into 14:15 the budget of the new wards.

DR. MAXWELL: Because they were separate bedrooms?

A. Yes.

DR. MAXWELL: Down different corridors?

A. Yes. 14:16

DR. MAXWELL: And you couldn't see them from one point?

A. Correct.

DR. MAXWELL: Thank you.

187 Q. MR. McEVOY: At the bottom of page 93, Mrs. Steele, you talk about how you did not use nursing staff while you 14:16 were at Muckamore, or additional staff resources were needed as cover would come from our own permanent staff by bringing in temporary staff, an additional nursing staff resource in that there was bank of around 100 nursing staff. 14:16

Across in on page 95 paragraph 391, you say:

"I did not use agency staff during my time at

Muckamore. While cost was a factor, there were no agency nurses available who had training in learning disability."

You were able to operate, you say, a big enough bank of nursing staff so did not need to seriously consider agency staff. 14:16

"Agency nurses are trained in general nursing only. The introduction of staff agency members would have been an unknown quantity. While an agency can say what training and experience that a staff member has, that may not be appropriate to Muckamore and the needs of the patients. I and the other senior nursing team members who would have arranged cover knew their bank nurses, knew their skills and so could make appropriate staffing decisions." 14:17 14:17

The Inquiry has heard some evidence about the use of agency nursing staff since your retirement. Do you have a view about that, the use of such staff at Muckamore on the basis of what you told the Inquiry in those paragraphs? 14:17

A. I suppose I am away too long to know what training and what skills the agencies would have to give a fair answer on that. When I say the bank was big enough, it was. It was ran pre-Belfast Trust as a Muckamore bank, and then the bank, the central bank in Belfast, managed the service but still we knew the staff that were 14:17

suited or wanted to work within Muckamore. I don't know that I -- well, from a cost thing, imagine if I was still there, I would still be reluctant to use agency unless I really had to, but it would be unfair to comment on the skills. 14:18

188 Q. Can I just press you on one point. You say that the introduction of staff agency members would have been an unknown quantity?

A. Yes. Sorry, what I mean by that is the training that the bank staff had and the induction that they had, Muckamore had control of. 14:18

189 Q. Yes.

A. For instance, the staff would have been doing MAPA training, at least in the breakaway if nothing else, with trainers from Muckamore, and had an induction in the other mandatory subjects that we wanted. 14:19

190 Q. Yes.

A. And agency had been, I know, using other places but they wouldn't have had -- at my time, they didn't have the expertise in actually working in learning disability. 14:19

191 Q. Away from perhaps considerations of expertise and learning disability, there might be the human factor of continuity of care, in other words patients being familiar with certain members of staff; that might not be as achievable perceivably with agency staff. Is that a possibility? 14:19

A. That was a possibility although I am assuming that you're able to block book maybe agency staff if you had

vacancies that you couldn't fill. But that would have been the case with bank staff. Bank staff, some were actually allocated almost on a permanent basis to wards and were worked that way, with an overview by Senior Nurse Manager as well that there was no...

192 Q. I was just going to ask you about the bank staff. At 383, back on page 94, you tell us that you monitored bank staff performance. In addition, you monitored the number of shifts that bank staff were doing so that bank staff members were not overworking. You monitored the use by individual wards of bank staff. Where a ward was using bank staff more than you had expected, then you would have argued for permanent nursing staff to be allocated to that ward. 14:20

Tell us more about the monitoring and the process that you used and the trends you were able to establish.

A. One of the senior nurses was allocated to have responsibility for the monitoring of the recruitment and overseeing of bank staff, and making sure that, for instance, their induction was completed, that the reports that we would have taken after a period of time were all done, and a file put in any training needs identified. Whenever bank staff completed shift, it was authorised by -- it went through the general nursing office for the authorisation, unless it was pre-agreement, like somebody had been allocated to a ward and the nursing officer or Senior Nurse Manager for that ward took responsibility then for ensuring 14:20 14:21 14:21

that they weren't being overused.

Thinking particularly of our own, this permanent staff at Muckamore who maybe were on the bank, that they weren't working what would have been seen as too many hours in breach of working time directives. Also, there would have been spot checks done -- 14:22

193 Q. Sorry to interrupt. Would that have been a consideration then, that legal obligation around maximum working hours? 14:22

A. Yes. It would have been -- well, there was actually, if I recall, somebody could sign that they were working above the extra hours, but it was still the role then of the Ward Manager and feeding back to the Senior Nurse Manager if there was any problems identified -- 14:22

194 Q. Yes.

A. -- by a staff member, seeing their performance or in their attendance or in their attendance of their substantive post.

195 Q. You were going to say something about spot checks when I interrupted you. 14:22

A. Yes. I was going to say there would have been spot checks on the bank staff return sheet after every shift. That was signed by the nurse in charge, and the Senior Nurse Manager or the Ward Manager would have completed spot checks once a month just on the signatures and that the shifts had been completed and everything was above board. 14:23

196 Q. All right. Turning across to page 97 --

CHAIRPERSON: I'm so sorry but the spot checks would simply ensure or check attendance?

A. Yeah.

CHAIRPERSON: Rather than anything else?

A. Yes. There was a case of fraud identified once where a member of staff had completed, filled in bank sheets, and she hadn't worked shifts and it had slipped through. So following that period, a review -- 14:23

CHAIRPERSON: That was what that was for?

A. Yes, that's exactly what it was for. 14:23

DR. MAXWELL: But bank nurses were subject to an annual review of their conduct and competency, I presume

A. Yes, they would have been if they had have been... Yeah, they were. Yes.

197 Q. MR. McEVOY: Paragraph 398 on page 97, Mrs. Steele. 14:24 This is a topic we discussed earlier in your evidence, and indeed you touched on a few points that were raised in your evidence particularly to questions from the Panel. We're talking again about the Vulnerable Adult Policy in 2007. It's really just to allow you an opportunity to close off these issues that arise. How did you feel when social workers took over from nurses in responding or in handling the safeguarding incidents? 14:24

A. I had absolutely no problem with that. You know, I had no issue with it. 14:24

198 Q. Yes.

A. At all.

199 Q. Was it a net positive or a negative; was there any

improvement?

A. It was positive in that it was another set of eyes, it wasn't just nursing looking at it. Certainly it maybe eased the workload for some of the senior nurse managers to do something else. Social workers initially in my time, and remember the training was only rolling out by the time I finished, I would have had a managerial link in with the social workers just as the site manager, if you like. So I would -- they would -- I would have been aware of how obviously the investigation was progressing. It's not to say that I was ever felt left out or not included or not being involved in the findings, and they were quick to point out if there was anything that needed... But I am not aware of any issues between the social workers and the nurses, the senior nurses. 14:25 14:25 14:26

200 Q. Thank you. Then overleaf on page 98, Mrs. Steele, paragraph 407 towards the bottom of the page, you say:

"When I retired, I thought I was leaving behind a good service that would grow and become a regional service with a good resettlement function. I cannot believe, when I hear some patient names, that they are still in Muckamore. How is it that some of these patients at Muckamore that I knew, who had resettlement plans in 2010, are still there? I do not understand this." 14:26 14:26

Albeit it's an opinion that you're offering, can you offer any insight of your own to the Inquiry about how

that could be?

A. I mean, this is something that really saddens and frustrates me because when I left there was a really good regional resettlement group run from the Department that every Trust in the province attended - finance, advocates, families, the housing associations and independent sector - and there were plans for things to happen, things to go on. This was based -- a lot of it was based too on field trips that we had to Scotland and various places at different models of resettling. I just, I just don't understand how, like, 13/14 years later there could still be some people there that there hasn't been provision for. I just don't understand it. Some of these were children who had come in as children, maybe at 10 and 11. 14:27 14:27 14:28

201 Q. Mrs. Steele, those are my questions. It may be that the Panel have some more. Thank you very much.

QUESTIONS BY THE INQUIRY PANEL

14:28

CHAIRPERSON: I have only one clarification. Just give me a sec. Yes, Mel Carney.

A. Yes.

CHAIRPERSON: You mentioned earlier, where did Mel work? 14:28

A. He worked in the Mental Health Community.

202 Q. Right.

A. He was the Service Manager for Mental Health Community Services in Belfast Trust, yeah.

203 Q. So not based, obviously, at Muckamore?
A. No.
204 Q. So when you gave evidence about, is it a Mr Carney?
A. Mr.
CHAIRPERSON: Ms. Carney? 14:29
A. Mr.
CHAIRPERSON: Mr. Carney. When you gave evidence about Mr. Carney, as it were, taking the role at the senior nurses meeting, who was attending that meeting from Muckamore? 14:29
A. Nobody, or from learning disability.
CHAIRPERSON: No. That's all that I wanted to ask. Can I thank you very much indeed. Your evidence has been informative and enlightening, and I'm very grateful for giving up all that time for making a very 14:29 lengthy statement and giving us your time today. Thank you very much indeed.
A. Thank you.
CHAIRPERSON: Okay. If you'd like to go with the secretary to the Inquiry. 14:30
A. Thank you.
CHAIRPERSON: Is that you done, Mr. McEvoy?
MR. McEVOY: That's me signing off, Chair. Ms. Briggs has a read-in in relation to H903. 14:30

STATEMENT OF H903 REFERENCE 253 READ BY MS BRIGG

CHAIRPERSON: Okay. I think we can go straight into that, if Ms. Briggs is ready.

MS. BRIGGS: Chair, Panel, the reference is 253-1, it is H903.

CHAIRPERSON: Okay. Sorry, just give me a second. And there is no application in relation to this?

MS. BRIGGS: There is no application to the Panel. 14:31

This statement is dated the 17th March 2024 and it reads as follows:

"I, H903, make the following statement for the purpose 14:31
of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement.

My connection with MAH is that I worked summer relief in MAH in 1997. From 1998 to 2006, I was a bank health 14:31
care worker in MAH. From 2006 to 2016, I was employed as a nurse at MAH. I left my post in MAH following the end of maternity leave in 2016. I began my role as a behaviour specialist in the community employed by the Northern Health and Social Care Trust in 2017. I 14:31
remain in this role."

Paragraph 2 just repeats those timeframes, Panel. Picking up paragraph 3:

14:31

"I qualified as a registered Learning Disability Nurse in 2006. Prior to qualifying as a nurse, I obtained a graduate degree in Spanish and Politics, and completed a postgraduate diploma in European Business

Administration. As a student, I worked as a domestic in Antrim Area Hospital. In July and August 1997, I worked summer relief as a healthcare worker on Fairview in MAH. This was a full-time post and covered full-time staff holiday periods. 14:32

Fairview was a female ward for older ladies with severe learning disability. During my postgraduate studies, the Belfast Health and Social Care Trust advertised for bank healthcare support workers for MAH. As I enjoyed 14:32
working in MAH as summer relief, my experience encouraged me to apply for the bank healthcare support worker post. My application was successful and I began as a bank healthcare worker in MAH in 1998. I cannot recall the interview process. I recall attending 14:32
mandatory induction training provided by the Belfast Trust, some of which included manual handling and infection control within the MAH site. I did not know anyone who worked in MAH prior to working as summer relief staff. Prior to working as relief and bank 14:33
staff, I had no experience working within a learning disability setting.

I enjoyed working in MAH and felt good job satisfaction so I decided to return to study to become a nurse. I 14:33
began my nursing degree within Queen's University Belfast in 2003. I continued to work as bank staff in MAH during this time. As bank staff, I rotated through wards in MAH depending on staffing needs. I worked on

Rathmullan, Conicar, Fintona, Foy Beg, Finglass, and Movilla. Finglass was a ward mostly for those with physical disability. Movilla was the male assessment ward. I remember very little about these wards with the passing of time. I enjoyed working in them. I do not remember ever witnessing physical intervention or seclusion, which would only have been relevant to Movilla. 14:33

I worked day shifts as a bank healthcare support worker and may have worked some night shifts. As a healthcare support worker, my role was varied and I enjoyed the different experiences in different ward settings. I gained a lot of experience in caring for patients with a learning disability who each had different needs. I was supervised by trained staff on each ward. At the beginning of each shift, the nurse in charge gave me an allocation list of my tasks for the day. This included the name of the patient I would be caring for and which staff member I was to work with. I reported any change in patient's baseline behaviours to the nurse in charge. I was aware of baseline behaviours from their care plan and by working with them regularly. I could identify changes in behaviours. For instance, if they are normally chatty and the next day they were quiet and lying on a sofa; if someone looks like they were uncomfortable using the toilet; if someone was sleeping more often than usual. 14:34 14:34 14:34

I provided good care by keeping the patient within their routine."

And the witness describes in that paragraph the type of tasks she would have done. 14:35

Picking up at the end of paragraph 6:

"I may have been assigned to a group of patients and worked one-to-one with other patients as allocated by 14:35
the nurse in charge. Sometimes I worked with a patient on my own and other times I worked with another member of staff.

The care I provided was patient-centered and included 14:35
therapeutic activities depending on patient need and what they liked. I recall playing games with patients, taking patients, both those mobile or in wheelchairs out on walks, and helped to teach them new skills, e.g. how to brush their teeth. I enjoyed taking patients 14:35
swimming within the hospital, which was a preferred activity for many."

The witness says at paragraph 8 "The care provided was adapted to suit individual need", and she gives 14:36
examples about this throughout paragraph 8.

Picking up at paragraph 9, page 4.

"Working in MAH was challenging on occasions as there were high levels of severe challenging behaviour which led to staff being assaulted, other patients being hurt or patients trying to hurt themselves. Some wards did not experience patients with challenging behaviour and some wards did." 14:36

The witness goes on in the next few sentences to give examples of the types of challenging behaviour that might have been seen. 14:36

Towards the end of paragraph 9:

"I got to know patients and recognised when they were upset, which could lead to them displaying challenging behaviours. As I had a good relationship with patients, there were many times when I de-escalated potential situations by talking with them, taking them for a walk, or distracting them and redirecting them to a preferred activity. I could report and call on colleagues for any support needed at these times. Some days could be more stressful than others as the day could be busy with lots of appointments or events happening, e.g. dental appointments, discos, hospital appointments, or days where there were staff shortages or managing high levels of challenging behaviour. On these occasions, the nurse in charge of each ward encouraged staff to support each other by working as a team and remaining calm. If I needed support, guidance 14:36 14:36 14:37

or advice, I could approach any trained member of staff. This approach was applied across each ward. The role I was allocated changed over the course of my shift so that I was not assigned to the same person or group throughout my whole shift, which was a positive because it meant that my role was varied across shifts.

There were times when patients expressed that they did not want certain staff to look after them as they preferred another member of staff. When a patient did not like being cared for by a certain member of staff, it was noted on their records to ensure this was avoided where possible and within reason as some patients simply preferred certain staff but it was not possible for the staff member to care for them every shift. New staff got to know patients via preferred staff and this helped widen the patient's preference of staff. Where a patient specifically targeted the same member of staff often, their risk assessment recorded that either the staff member was not to care for them due to risk, or to ensure that more than one staff member would be responsible for caring for that individual.

I recall a young person with mental health difficulties who often became agitated with particular staff caring for him. Initially this started with him not wanting a specific young female member of staff to care for him, which then progressed to nearly all members of staff.

This involved this young person running at and severely attacking the members of staff by hitting, kicking and pulling their hair very aggressively. This patient progressed to two-to-one staff ratio care due to the risk posed to himself and others, and to give him enhanced support. This also ensured staff were not vulnerable to these behaviours working with the young person alone due to the risk posed. Thankfully these behaviours reduced as the person's mood improved. 14:39

As a healthcare worker, I had contact with families when they came to visit patients. I was not involved in any discussions with families about patient care plans. I brought patients out of the ward to the visitors room to meet their family and to give the family privacy. If a patient was displaying challenging behaviours, with the family's consent or at their request, I sat with them during the visit to help the family in case the patient became aggressive. I chatted about the patient's day and the activities that we had been enjoying, accentuating positives of the day within the patient's earshot. 14:39 14:39

MAH was a community where service users had access to everything on site, to include discos, a swimming pool, a cafe, transport and walks around the grounds. A lot of patients were able to have the independence to socialise and go places within MAH on their own unsupervised. This included going to work skills, to 14:40

the shop or to the disco. This helped them build confidence and boosted their self-esteem. This may not have been achievable within community settings due to their vulnerability and the higher risks posed. Patients regularly engaged in community activities and trips out."

The witness gives examples of activities and trips that were undertaken.

Paragraph 14: 14:40

"Staff on each ward I worked on treated patients like family. Some patients did not have family to go home to at Christmas, for example, so staff who cared for them often volunteered to work over the Christmas period to support them. Staff made Christmas fun and festive for patients by supporting them when they were missing particular people. 14:40

I continued to work as a bank staff in MAH throughout my studies and training as a nurse. As a student nurse I completed five six week student training placements in MAH. After completing my first year in general nursing in Belfast City Hospital, Belfast, Holywell Hospital Antrim, and Royal Victoria Hospital Belfast, I undertook a six-week placement in and around 2004 on the Rathmullan Ward. Patients on Rathmullan were adults with profound physical and learning disabilities. Some patients required help with their 14:41 14:41

mobility and used wheelchairs. Patients on Rathmullan were long stay patients. I would describe Rathmullan as a big ward. It had side rooms at each end and a dormitory in the middle. There were three day spaces and three dining areas. There was a kitchen, medical room and staff room on the ward. All areas used by patients were wheelchair accessible." 14:41

In the next paragraph the witness describes risk assessments that were in place for patients and staff. Picking up at paragraph 17, page 7: 14:42

"I do not recall behavioural support plans for patients on Rathmullan, as they displayed very little challenging behaviours and hence these were not needed. I am not aware of PRN sedation medication being administered to patients on Rathmullan. Medication I recall that was prescribed was based on their health needs, e.g. anticonvulsant medication. 14:42

Families visited patients on the ward. The care in Rathmullan was exemplary. It was a quiet and peaceful ward. There was a good atmosphere on Rathmullan. Staff engaged patients in therapeutic treatments like hand massage, music, and walking around the grounds. There was a sensory soft play area for patients to relax in. I remember there was lots of laughter and chat between patients and staff." 14:42

In the next three paragraphs, the witness describes their experience working on Conicar, the children's ward, in 2004 for six weeks, and the witness describes the atmosphere there as good.
Page 8, paragraph 22: 14:43

"I worked for six weeks on Foy Beg Ward as a student in approximately 2004. This was a ward for men, some of whom may have been diagnosed with a learning disability and a mental health issue. A lot of patients were very 14:43
independent with their care needs, personal hygiene and leaving the ward. I supported patients by helping them at meal times and gave whatever assistance was required. I got to know them and their likes and dislikes. This placement gave me insight into dual 14:43
diagnosis and treatments.

I undertook two six-week placements on Fintona Ward in 2004 and 2005. My second year placement was near the end of my training which focused on management in late 14:44
2005. Patients on Fintona Ward were adult females admitted for assessment and treatment. Patients were admitted from home or from a residential unit or were a placement which had broken down. When a patient was admitted, I sat with the trained member of staff and 14:44
helped gather information about the patient. I spoke to the patient's family, social worker and any other person involved in their care. This information was gathered to identify the patient's needs to keep them

safe. For patients who were admitted before I began my placement, I was made aware of each patient's needs by trained staff and by reading their care plans.
On starting each six-week placement as a student nurse, I received inductions specific to the care needs of 14:44
patients on each ward. The culture on each ward was good. Staff worked in teams and got on well with each other. There was good communication and multidisciplinary working among staff. Teams welcomed 14:45
students and were of great support. There were good reporting systems, openness and transparency, and many staff came in and out of units as part of their roles.

As a student nurse, my role was to shadow trained nurses to learn how to provide medical and personal 14:45
care to patients. I gained independence as my training progressed. At the start of each shift, the nurse in charge provided all staff with a handover. The nurse in charge allocated my responsibilities for each shift.
I was made aware of each patient's skills and care 14:45
needs, along with details of what they liked and did not like. I could access patient medical files but their care plans were more relevant to my role.
Relevant information from the patient's medical notes was reported in the patient's care plan. My tasks 14:46
included weighing patients, feeding them, ensuring that they were comfortable, and escorting them to day care.
I had access to patient care plans and medical records so I was aware of any dietary needs, speech and

language advice and their mobility needs. Treatment plans included details of medication to be given to patients, and risk assessments to ensure patient safety. Some patients had very little communication skills and were non-verbal, meaning they struggled to communicate, which was noted in their care plan. 14:46

I learned how to carry out assessments on patients as part of my training. To assess a patient, I had to communicate with them or observe them. A patient's treatment plan set out how best to communicate. For patients who were non-verbal, I could tell how they were feeling by reading their facial expressions and using strategies approved by speech and language therapists. For example, patients may have used a choice board to communicate. I observed patients in different situations, environments, with peers and with family, and was able to report on this. I learned how to complete the nursing assessment based on Roper, Logan & Tierney's Activities of Living, and developed care plans from this. 14:46 14:47 14:47

Patient care plans included 15 activities of living to include details of behaviours displayed by the individual, socialisation, and any other relevant care identified by the multidisciplinary team. I attended multidisciplinary team meetings which I believe were held weekly. The MDT reviewed each patient's weekly report and discussed if any changes to their care plans 14:47

were needed.

I met many trained staff and healthcare workers who provided exemplary care. They were professional, compassionate and caring. They had very obvious great relationships with the patients. They were able to support patients well and remain calm under pressure, helping the patients to feel better and problem solve. The staff I worked with were good leaders who showed good practice and acted as mentors for my learning. The full team was equally important. Healthcare support workers were invaluable, they knew everything about the patient's needs. They played a vital role and were a great support to patients and trained staff in their roles also. 14:47 14:48 14:48

My management placement on the Fintona Ward in 2005 as a student included taking more responsibility for patients. For example, I was responsible for the care of four patients." 14:48

And the witness gives more detail about that in the rest of that paragraph.

Paragraph 30 then, halfway down page 11: 14:48

"Therapeutic treatments were documented in patient care plans. These included creating a relaxing environment for patients, like reading them a story or listening to

music. Some patients liked guided imagery, lying on the sofa with a relaxation script and chill-out music. This formed part of patient care plans and formed part of their regular routine. Developing structure and routine for patients was important for their care and keeping them engaged in meaningful activities. I and staff always tried to help patients to find new more positive ways of dealing with emotions rather than the use of aggression. 14:49

Cognitive behaviour therapy (CBT) was used for some patients as a complementary treatment. The use of CBT depended on the patient's cognitive skills so where it was appropriate for some patients, it did not apply to everyone. 14:49

Where a patient was to attend hospital off the MAH site, I carried out a management assessment to make sure the patient was dressed, knew where they were going, and why and how the patient was to get there. I ensured patients had been given their morning medication and would be supervised at all times. There were times when I escorted patients to hospital and stayed with them for as long as needed." 14:49 14:50

The witness goes on then to describe in particular the management and care of patients who had epileptic seizures.

Paragraph 33 then:

"I organised the staff rota under supervision of my allocated mentor. I cannot recall the name of my mentor but they had to be Band 5 registered nurse or above who undertook designated mentor training with at least one year experience in practice. I worked alongside my mentors during my placement and part of my role was to allocate tasks to staff. I worked with nursing assistants and trained staff. 14:50

There were times when physical intervention and seclusion were used on Fintona as a last resort. Some patients displayed challenging behaviours with high levels of aggression that could put the patient and others at high risk. Physical intervention was used when other methods of de-escalation did not work. It was a last resort and used for the shortest time possible. If a patient seemed agitated, I would redirect them by talking to them or changing their environment by taking them outside for a walk. At times I offered a motivator by offering a preferred activity, encouraged them to relax by taking a bath, or offered a cup of tea or a biscuit. If a patient needed space, I made sure that this was provided. If I could see what was triggering the patient, I tried to remove it. Some patients' behaviour went from nought to 100 very quickly and were very impulsive, which was harder to manage. 14:50 14:51 14:51

If physical intervention was used in circumstances where other de-escalation methods did not work, it was recorded on a patient's care plan in the evaluation notes and on a physical intervention audit form. Each 14:51
care plan was patient-centered and set out what may upset the patient. If it were recorded that a patient was triggered by noise, for example, staff would make sure to take the patient away from the noise where possible. If a patient was agitated and I needed 14:52
assistance, I called for help or hit my personal alarm. If physical intervention was used, this was recorded on physical intervention audit forms and the patient's care plan. I cannot recall a particular example of when physical intervention was used, but I remember 14:52
either a member of trained staff or the staff member who the patient had the best relationship with at that time would take the lead in communicating with the patient to help calm them whilst other staff supported them." 14:52

The witness goes on to give detail about how difficult situations like that were managed.

Paragraph 36 at the bottom of page 13: 14:52

"There was a seclusion room on Fintona. Seclusion was used as a last resort. De-escalation continued throughout while the patient was upset. The seclusion

room was seen as a low stimulus room so it may have been used as a quiet space to help the patient settle. It was not needed for seclusion all the time so the door would remain open. Trained staff took lead in relation to using seclusion in that they would contact the medical officer who authorised seclusion and draw up a specific seclusion care plan. I was aware seclusion happened but I cannot recall it being used during my placement. Whether the door was required to be closed or left open was documented in the patient's care plan. Staff stayed with the patient at the seclusion area to offer support and reassurance. 14:53 14:53

I qualified as a nurse in 2006. Learning disability nursing requires nurses to care for a person holistically, be aware of individual communication and sensory needs, as well as being capable of carrying out clinical skills. Learning disability nurses have specialist training to work with patients with a learning disability, and their families, to support them, optimise their health and wellbeing. 14:53 14:54

There is an emphasis on the building of therapeutic relationships within learning disability nursing which is important. Some patients with a learning disability present with challenging behaviours. Learning disability nurses are well aware that there is always a function for these behaviours, be it to communicate their needs, to escape or avoid situations that are 14:54

hard for them, to gain an interaction, or to have a sensory need met. I am aware of the importance of recognising triggers and how to avoid them.

Shortly after I qualified, the Belfast Trust advertised for Band 5 nurses in MAH. I got the job and was allocated to work on Conicar Ward. As a newly qualified nurse, I undertook a preceptorship programme for six months. Under the programme, I worked independently and was supervised by members of trained staff on each shift as well as having a designated perceptor. As part of my role I administered medication, linked in with the children each day, organised trips and events, became a named nurse for children, and attended meetings as required.

Patients were assessed on admission to Conicar. I met with parents, social workers and everyone involved in the child's care to gather information, and I also met with the children. For those who were non-verbal, they used signs, or if they wanted to show me something, they would take my hand for me to follow them. After assessing the child's skills and needs, a care plan was prepared by the named nurse."

14:54 14:55 14:55 14:55 14:55

In the next paragraph, paragraph 40, the witness gives some more detail on how patients were assessed in Conicar.

Paragraph 41:

"As a Band 5 nurse, I was responsible for delegating work to Band 2 and Band 3 staff. I supervised staff working alongside them, and acted as a role model and was there for support. I also allocated roles to them, to include bringing children to school. Where a group of boys were travelling to school outside MAH, they were allocated taxi and escorts by Social Services, and their supervising staff remained on the ward until they returned from school. For children who needed one-to-one supervision within the ward, the carer stayed with them for the duration of their school day if they were schooled on site. 14:56

The culture on the ward was for everyone to work together, ensure good communication, openness and team work, and showing care and compassion to both the children and their families and to colleagues. It was common for Band 5 staff to work with Band 2 and Band 3 staff doing tasks, to include putting laundry away or doing activities in the day space or garden area. 14:56

There was a good working atmosphere on Conicar. All staff were friendly. As Conicar was a children's ward, there was a lot of singing and dancing and fun. All staff worked as a team and no-one was too senior to carry out tasks. The aim was always to do what was best for the children and if support was needed, 14:57

everyone helped. The Ward Manager H122 often took kids to the swimming pool at MAH and led by example. I felt supported in my role. If I was stressed or having a very busy day, I could speak to the team.

I got to know parents of patients and their visiting schedules. Some families visited every evening whereas some visited on a Saturday morning. I formed good relationships with families. Families could come onto the ward but they usually met in a visitor room. The reason for this was to protect the other children's privacy on the ward and let the families enjoy a private visit. We worked in partnership with families, sharing information of what works well and what does not work well. A lot of children went on home leave maybe for one or two nights a week, depending on each individual's situation. There was careful planning of starting home leave to help it go smoothly, and there was good communication between parents and ward staff to help support the children." 14:57 14:57 14:58 14:58

In paragraph 44 the witness describes the daily care of patients in Conicar. Picking up at paragraph 45, page 17:

"Patient care plans are reviewed at least every six months. A care plan could be changed at any time if a need was identified. Where a patient's condition changed since the time of drafting the care plan, for example, their bowel movements were regular but this 14:58

changed to the patient suffering from constipation, their care plan was changed immediately with the issue reviewed and monitored.

The MDT carried outward rounds on a weekly basis when they reviewed patient care plans. Meetings were attended by the Ward Manager or a Band 5 nurse, a consultant, social worker, psychiatrist, speech and language therapist, behavioural specialist, psychologists and teachers were required. Children were monitored under the Looked After Children Review, which is part of the child protection policy and procedures applied within three months of admission and at least six monthly thereafter. All children within MAH were deemed Looked After Children under the Children Order (Northern Ireland) 1995. Some were also admitted under the Mental Health Order (Northern Ireland) 1989. 14:59 14:59 14:59

MAH did not have a computerised system that held patient notes and records and care plans until PARIS was introduced in approximately 2013. Patient notes and records were held in the ward office. An allocated nurse was responsible for updating patient notes to include any that needed to be updated immediately. All trained staff documented in the daily evaluation notes of the care plan. Documentation was based on the activities of living, e.g., a patient got up at 8:00am, he was in great form and ate all his breakfast, he 14:59 15:00

proceeded to school at 9:15am with his taxi and escort.

Patient's Kardexes were kept on the medication trolley locked in a clinical room and held in the medical notes. It was referenced to find out what medications were prescribed to patients. All medications were also set out in patient care plans. 15:00

At the start of each shift, the nurse in charge from the previous shift provided a handover of all patients within the unit, updating staff with all relevant information over the past 24 hours. Handover included informing staff if a patient did not sleep well, which was unusual for them, or if a patient experienced abnormal bowel movements. If PRN was administered, details of how much, when it was administered and the patient's reaction was shared. PRN medication was recorded on patient's Kardex and care plans. 15:00 15:01

I could administer medication but not prescribe it. If a patient needed Paracetamol for a sore head which was not listed as a prescribed medicine on their Kardex, I telephoned the doctor on the rota to obtain a prescription. I rang the doctor who was based in MAH. If the doctor was on another ward, I could bleep them to make contact with me. The doctor usually made daily visits to the ward. To assist the doctor, nurses completed a diary that provided details on what staff thought the doctor needed to look at when assessing a patient. 15:01 15:01

A trained nurse met with the doctor to talk through any details recorded, and assisted the doctor with any examinations required. Where a doctor assessed that a patient needed medication, if this was discussed over the phone, they would authorise the administration of Paracetamol, for example, and then come to the ward and write it up as a stat/once only dose, and also add Paracetamol to the patient's Kardex as PRN in the event that this was needed again. 15:02

Some days were difficult if children were agitated or unwell. If a child's behaviours escalated, I used proactive strategies like redirection, and use of diversion techniques like taking the child to a quieter environment or for a walk to help them de-escalate. My approach was in accordance with individual needs. I attended MAPA training to include how to use physical intervention. MAPA used the same techniques for adults and larger children. When I use the term "children's unit", there were very few small children but rather large teenage boys were the majority. Physical intervention was not required for younger children as their behaviour tended to be managed easier due to the smaller size and also as there were very few small children admitted. Physical intervention was used as a last resort and only when reasonable proportionate and justifiable for the risk posed." 15:02 15:02 15:02 15:03

The witness gives an example of unnamed 16 or 17-year-old boy who she says was aggressive towards patients and staff, and she described how physical intervention was used on him, and support would be given to him and to staff when it was used. 15:03

The end of that paragraph 51, it's about halfway down page 19:

"Physical intervention audit forms were completed and the patient's parents and social worker were updated that intervention was required and how the young person was now. A body chart was also completed. The named nurse added this information to the care plan. 15:03
Incidents where physical intervention was used were reviewed by the MDT at ward rounds, who would consider any changes to patient care plans that may reduce the risk of patient behaviours escalating. Any changes were shared with staff by the nurse in charge.
Where an incident occurred, an incident copy paper form 15:04
was completed with details. The form was sent to the nursing office, with a copy put on the patient's care plan and a copy left in the book. Information recorded on the incident form included details of what occurred, e.g. if a patient was injured due to their behaviour, 15:04
had tripped, or any near misses. Band 2 and Band 3 staff reported any incidents to me as a Band 5 nurse. Trained staff completed the incident form and added information to the care plan. I cannot recall examples

of particular incidents. As time progressed incident forms moved from paper copies to DATIX.

I worked with Allied Health Professionals when children were preparing to return home or move to a residential unit. I was involved in preparing resettlement care plans for patients. If a child for whom I was the named nurse, caring for them, was moving into supported living accommodation, I met with the care provider to share information on care needs. I remember working with a boy of 16 or 17 who moved into supported living accommodation with either Positive Futures or Autism Initiatives in Belfast. He did not like overcrowding so it was important that the environment met his needs. He was to live in a bungalow with one other person. I met with care staff and visited the bungalow to assess the environment. To help him settle, I stayed with him on his first night in his new home. The resettlement was successful. I was involved with the team in helping resettle a lot of children into the community. Some had bespoke community packages, and transition to the new setting went smoothly. 15:05 15:05 15:05

When Six Mile Ward, which was a forensic ward, was built in MAH in approximately 2007 or 2008, patients and staff on Conicar were moved to Mallow on the MAH site as it was not appropriate for children to remain on Conicar. I think that there were 16 beds on Mallow but they were not always full. Some children were 15:06

delayed discharges. I worked in Mallow for two to three years until the ward was moved to the Iveagh Centre when it opened on the Falls Road in Belfast. Iveagh is an eight-bed unit. I do not recall how many children moved from Mallow to Iveagh, possibly between six and eight, with the remainder moved to Somerton Road Residential Unit following discharge from MAH. Staff on the ward worked hard to provide information to Somerton Road staff and support the children moving there, as well as planning for the full ward transition to Iveagh." 15:06 15:06

Paragraphs 55, 56 and 57, in those paragraphs the witness describes Iveagh, which opened in 2010. If we pick up at paragraph 58 towards the bottom of page 21: 15:07

"Prior to Iveagh opening, I had been promoted to Band 6 Deputy Ward Manager. This was a new role within MAH. I took on more responsibility to include organising staff rotas, supervising staff on the ward, and splitting shifts with senior nurses, liaising with MDT and auditing care plans. At times there were staff shortages due to holidays, sickness or injuries at work. A more consistent staff team was built up with the creation of Iveagh. There was a high turnover of staff in Mallow. Staffing levels could cause issues. At times there were more children needing increased one-to-one care or two-to-one care due to the risk to themselves or others on the ward which tended to 15:07 15:07

increase staffing levels. If there was a staff deficit, sorting out staffing was one of the first jobs on the shift each day."

In paragraphs 60 through to 63, the witness gives more information to the Inquiry about Iveagh. I am going to pick up at paragraph 64 on page 23, about halfway down: 15:08

"In approximately 2013 I was promoted to Band 7 Ward Sister in Iveagh. This role further increased my responsibilities. I attended nurse management meetings held in MAH. We discussed policies and procedures, objectives, any reviews received, recruitment needs and anything of relevance at the time. These meetings were a good opportunity for me to liaise with and learn from staff working on other wards, and to keep up to date with relevant policies, procedures or any new initiatives." 15:08 15:08

In the next two paragraphs the witness describes further her role at Iveagh, including in relation to discharges. 15:08

Paragraph 67, page 24:

15:08

"I developed good relationships with parents during my time in Iveagh, and my communication was based on openness and transparency. We worked in partnership with parents who were involved in their child's care

plan, and consented to each aspect of their care. Some parents rang every evening at 6:00pm for an update on how their child was that day. Parents were aware of any changes to the patient's medication or care plan following ward rounds." 15:09

The witness goes on to describe her contact with families in that paragraph, and at paragraph 68 she describes policies and procedures. She says there: 15:09

"Policies and procedures such as the management of aggression policy were well communicated to staff. Policies were printed and all staff signed as read. Some days seen no incident forms and other days multiple forms were completed. Incident forms were completed for anything untoward which happened on the ward", and the witness gives examples about that, and also discusses audit forms. 15:09

At paragraph 69, the witness says: 15:10

"I do not remember any official complaints from parents of patients. There were some informal complaints from parents. I recall a complaint from parents around another patient wearing clothes that belonged to their child. I said that we would try to avoid this happening again and learn from it." 15:10

At paragraph 70:

"I did not witness poor care being provided to patients at any time during my time in MAH. I was aware of the whistle-blowing policy and to report any concerns I had about care to the nurse in charge or someone more senior. If I had witnessed poor care during my time at MAH, I would have reported it. In my role as a nurse or Ward Manager, I cannot recall anyone referring poor care to me. 15:10

I did not work on the forensic ward in MAH so I cannot comment on the use of EQUIP.

Throughout my time in MAH, I was permitted time to attend mandatory training. Continued professional development was promoted by senior staff in MAH. As part of my training in 2011, I was seconded to train as children's nurse through Queen's University Belfast for 18 months. I worked on the children's wards in the Royal Victoria Hospital, and with community teams in the Antrim area." 15:11

The witness says at paragraph 73, "I was not aware of CCTV on Conicar, Mallow or in Iveagh." 15:11

Paragraph 74:

"My experience of working in MAH was positive. It was a job that I thoroughly loved and found it rewarding.

I am extremely proud of being a learning disability nurse and of my time in MAH. The care was exemplary and therapeutic relationships were easily visible. Unfortunately, there was a high level of challenging behaviour which was very difficult to manage, and this was done with care and compassion. Many staff sustained injuries and continued to come to work, showing dedication and professionalism and providing good care. I think a lot of the patients in MAH tended to thoroughly enjoy being part of life there. They built great relationships with staff. Some of the children did not want to go on home leave as they did not want to miss out on the fun. It is disappointing and sad to hear of ongoing investigations within MAH as it does not reflect the care I witnessed given to patients throughout the years I worked in MAH." 15:11 15:12 15:12

Then the witness gives the declaration of truth, and signs and dates her statement.

CHAIRPERSON: Thank you very much. Thank you. What we'll do, there is one more statement to read which I think Ms. Tang is dealing with. 15:12

MS. BRIGGS: That's right.

CHAIRPERSON: We'll let everybody stretch their legs. We'll take 10 minutes now and then we'll carry on with the next one. Thank you. 15:12

<u>THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:</u>

STATEMENT OF HEATHER MCFARLANE REFERENCE 235 READ BY MS TANG

CHAIRPERSON: Yes, Ms. Tang.

MS. TANG: Thank you. Good afternoon Panel. The final statement to be read in this afternoon is that of Heather McFarlane; the page reference for it is 235. This is the statement of Heather McFarlane dated 22nd day of April 2024. 15:27

"I, Heather McFarlane, make the following statement for the purpose of the Muckamore Abbey Hospital Inquiry. There are no documents produced with my statement.

My connection with MAH is that I was a Band 7 occupational therapist at MAH on a full-time basis. The relevant time period I can speak about is between 2012 and 2015." 15:27

The witness then goes on to provide some details of her education background in paragraph 3. I won't read all of that but will skip on to section D of paragraph 3 where she tells us: 15:28

"In 2012 I undertook a secondment as a Band 7 occupational therapist with the Belfast Trust at MAH with Dr. Shelley Crawford, who had responsibility for 24-hour positioning and postural management at MAH." 15:28

She then goes on in her next paragraph to tell us about where she works at present.

Moving to paragraph 4:

15:28

"The remit of my role as a Band 7 resettlement occupational therapist included holistic assessment of individual's physical, mental health and social care needs and appropriate intervention, such as housing recommendations for discharge, including bespoke 15:29
housing design. MAH was provided with a budget by the Belfast Trust for a three-year term to employ two occupational therapists to support the implementation of delivering the Bamford Vision action plan 2012 to 2015, which was launched by Edwin Poots, Health Minter, 15:29
to progress the enhancements to Mental Health and Learning Disability Services started in the Bamford Review of Mental Health and Learning Disability Services 2002. There was recognition that we needed a focused shift on everyone having a home. Funding was 15:29
released to transition people from long stay wards into community homes, and outcomes were to be closely monitored by the Executive.

At this time MAH recognised the need for additional 15:29
expertise in relation to the resettlement of patients from long stay wards, which culminated in the development of two occupational therapy posts."

The witness then goes on to tell us that she applied for one of those and was successful.

Picking up at paragraph 6:

15:30

"I understand from speaking from other MAH staff that during the 1990s, MAH had already resettled people from MAH into community homes. Long stay MAH patients were moved from long stay wards into the community between 1993 and 1998. I would not be able to comment on the previous process and procedure used for resettlement. I know that from talking with a senior colleague that MAH had not employed an occupational therapist for 30 years prior to this appointment in 2012.

15:30

15:30

When qualifying as an occupational therapist, I received general training covering a range of health conditions. During my time in MAH, I undertook postgraduate training, including an MSc module in sensory integration, and two systematic literature reviews."

15:30

She mentions these in Section 3C.

"This supported my clinical work in MAH. The challenge of this Band 7 post in MAH was immense but very rewarding to see people being resettled into their own homes after many years of long-term hospital care. Prior to working in MAH, I had 24 years occupational

15:31

therapy experience, 16 years of which had been as a community occupational therapist. I anticipated that this role would be an opportunity to apply knowledge and skills to support a new way of living for those with learning disabilities and complex needs. 15:31

When I joined MAH, I had no friends or family who worked there. I knew Dr. Shelley Crawford and was aware that she was a very capable, highly passionate about her work and exceptional in her field, having 15:31 obtained a national recognition in relation to postural management and 24-hour positioning. Initially at MAH I did not have an office, chair or desk but was given a seat in the library for recordkeeping, and immediately moved onto the wards to begin clinical work. There was 15:32 no official welcome when I joined. However, I was greeted by a very good nurse manager on site, H290.

H290 was the link between MAH and the Health and Social Care Board, and would have reported regularly to this 15:32 monitoring body in relation to the resettlement progress. H351 was the site manager, who identified an office for me to use in a disused building at MAH. When I began my role at MAH, many families of patients were not keen that their relatives were leaving MAH and 15:32 believed this was not offering betterment of care. Some staff also expressed concerns, particularly as some of the patients now in late adulthood had arrived as babies or teenagers and spent all of their lives in

the hospital, and they were unconvinced that the same level of care could be provided on discharge from MAH. It was important for me to appreciate these fears as we worked with staff and families to gain a history of these individuals, alongside holistic occupational therapist assessments, to inform the resettlement process.

Initially I experienced some hostility from nurses on the wards. I cannot remember which wards or nurses specifically. Comments were made such as "You've come to take our jobs", "You've come to take our babies", and "What you're doing is a load of shite." I was managed operationally by H29O in MAH and professionally by Aisling Curran in the Belfast Trust. My remit was to resettle all patients on long stay wards. People were often resettled in phases agreed by the HSC Board and MAH at the time. I worked on Rathmullan, Erne, Moylena, Old Park, Ennis and Greenan Wards.

We kept our notes separately in our occupational therapy files but also a copy of patient progress in the daily nursing notes and in the patient's file kept on the ward.

When patients were being discharged, we logged them on to PARIS, the electronic patient record, with OT reports so that these could be shared with community staff who used this electronic patient record system. I shared information with the nurses via written and verbal feedback to support the resettlement process,

highlighting the benefits of resettlement for individual patients. There were mixed responses. Some nurses appreciated the work being undertaken and the new approaches being used, such as H849 Ennis Ward, who, on seeing the benefits of sensory integration approach with patients, stated "I wish we had this years ago." Other nurses were less positive. I cannot recall the names of dissenting nurses. I required the support of all the nurses to assist with the needs and requirements of each patient to ensure the resettlement process could be executed in the best way possible. 15:34 15:35

In 2012 my first task was to focus on the resettlement wards, being Greenan, Ennis, Erne and Rathmullan. On resettlement of these patients, it was intended that the wards be closed. I provided no input into the remaining wards, nor was I responsible for supervising any staff. 15:35

MAH had a care manager known as H158 who worked in the community. H158 was not based on MAH site. She was a care manager based in the West Belfast community with a remit that covered MAH resettlement process. She followed those patients out from hospital into the community and supported them there on an ongoing basis. She attended meetings at MAH from time to time. I worked well with H158 and we focused on the wards to be resettled in addition to identifying suitable homes in the community. 15:35 15:35

Dr. Shelley Crawford and I provided evidence-based reports based on the assessed need, and worked with the Northern Ireland Housing Executive (NIHE) to identify housing that met the needs of people in the community. 15:36
Someone once said to me that all we would be doing from MAH was creating mini institutions in the community and I was determined that we would not be doing that. I worked with a local charity, Community Roots, to create a programme that supported community integration and 15:36
developed community living skills. The programme was shaped by requests from the patients being resettled. The collaboration between the Belfast Trust and the Community Roots was given recurrent funding to continue, based on its success. Resettling patients 15:36
into the community was challenging. However, I worked hard to ensure that recommendations from individuals' occupational therapy reports were implemented.

Part of my role was to identify and view potential 15:37
sites for resettlement and this included sites all over Northern Ireland. In the first 18 months of resettlements, only one patient returned to MAH. During the initial phase we focused on patients with learning disabilities who also required nursing care, 15:37
and identified accommodation to meet their needs. In subsequent months, patients with more complex needs and more challenging behaviours were resettled into community accommodation. It was more difficult to

provide bespoke accommodation at times for this population due to a lack of suitable housing.

I also worked with Inspire, an organisation that offered supported living packages to those who were resettled in Peter's Hill in Belfast. This was a newly built dwelling that supported adults with learning disabilities who often had associated mental health needs. 15:37

After three years, the funding ended and my role at MAH ended. After 2015 I understand that MAH was given dedicated funding to employ occupational therapists. 15:38

Initially when I started working at MAH, I did not have access to all of the wards and had to request access. Eventually I was given access to Rathmullan, Greenan, Oldstone, Erne, Ennis and Moyola Wards. Dr. Shelley Crawford also had access to Cranfield and Donegore Wards and I would have visited these wards occasionally with Dr. Shelley Crawford. 15:38

At the beginning of my time at MAH, there was an ongoing inquiry due to a whistle-blower and, as such, staff were suspicious of newcomers, which made access initially difficult on one ward in particular. 15:38

Due to the geographical location, MAH sits in a green field site outside Belfast. It employs local people from the surrounding small community. I was told by some staff that it previously had a village-like feel, and the hospital had contacts with local businesses,

for example, making toys, but this had ceased many years since.

I would describe the culture on the wards I experienced as institutionalised. In some cases boundaries between the staff and patients appeared to have become burden, with some nursing staff would frequently referring to the patients as "their babies" or "their boys". I cannot remember the names of the nurses who used those phrases given the passage of time. 15:39

When I started working at MAH I was told don't say anything about anyone as everyone is related. I do not recall their name. It was true that many of the staff were related, making the culture seem exclusive at times. 15:39

Dr. Shelley Crawford and I made a complaint about one nursing auxiliary to a member of staff, later to discover that it was his sister-in-law. His wife worked in the building where we had our office. The son of the Nurse Manager in MAH frequently used our office to share a computer. Husbands and wives worked in the hospital but on different wards. It was hard to tell who was related to whom as there were so many extended family members working within the site at the same time. Learning disability staff are a very small group across Northern Ireland, but more densely populated in a local town like Antrim. 15:39 15:40

I would describe the atmosphere as good and bad. The good atmosphere was reflected by some exceptional staff. We nominated one nurse for a national nursing award on witnessing her excellent end of life palliative care for a patient. I cannot recall the name of the nurse. The bad atmosphere could be identified by the lack of awareness among nursing staff, who genuinely believed they were doing their best for the patients. However, in certain circumstances the nature of the care was arguably not in the patient's best interests. For example, I witnessed a patient being restrained to a chair with a belt that was not appropriate. I cannot recall the names of the nurses carrying out this practice. 15:40 15:41 15:41

Learning disability nurses reportedly had little opportunity to attend a different hospital and were often required to stay at MAH if they sought to gain a promotion or progress up through the various bandings. There was a sense from staff that they were removed from the rest of the Belfast Trust, and weren't always aware of available courses or training. MAH was under the remit of the Belfast Trust but often didn't feel like part of the Belfast Trust due to the atmosphere described in this paragraph. This was reported to me on several occasions by different staff members, such as older nurses who had been working there a long time. I do not recall the names of those nurses. 15:41 15:41

The culture was difficult at times and I can provide a few incidents that I witnessed. The first incident relates to a nurse auxiliary who was transporting someone in an unsafe fashion, and I intervened. I reported the staff member to H397. I cannot recall the name of the nurse. H397 later advised me that the poor handling of the patient had been dealt with, although I was not privy to the outcome. I found out at a later date that the nurse was the sister-in-law of H397, which supports my earlier statement that there were many family connections in MAH. I cannot recall the date of the incident. However, I remember that it related to the Rathmullan Ward and, as such, it would have happened closer to the beginning of my tenure at MAH. 15:42 15:42 15:42

The second incident relates to a patient I visited in Greystone Support Centre, Antrim, when I was visiting a resettled patient in or around 2014 or 2015. When I arrived at the support centre, a patient was eating her dinner from a roasting tin with her hands. The patient had not been provided with cutlery or a plate. I reported the carer responsible to the manager of the Greystone Support Centre. This incident was only lacked dignity for the patient but was highly irresponsible due to the risk of injury to the patient who was forced to eat directly from a roasting tin. I understand that the male care assistant who was 15:43 15:43

responsible for the incident had been disciplined. I cannot recall the names of the individuals involved or comment on the nature of discipline, as this would have been managed under a nursing remit.

15:43

The third incident relates to an occasion when I attended Rathmullan Ward. When walking past the bathroom area, I witnessed two patients being assisted with toileting at the same time. The nurse in charge referred to the patients at "it" and told me that she would be over when she was finished with "this". I raised a concern with the nurse regarding any reference to the patients as "it" and "this", which appeared to be exceptionally undignified, and the nurse apologised. I did not escalate this issue as I felt it had been dealt with appropriately at the time. I cannot remember the name of the nurse involved.

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During the period I worked there, 2012 to 2015, staff still used paper notes, whereas the remainder of the Belfast Trust recorded information on an electronic system known as PARIS. I do not know why this was the case. A senior member of the MAH nursing team reported that a former Belfast Trust Chief Executive Officer, William McKee, who is now deceased, commented at an event during his time that he felt MAH should be part of the Northern Health and Social Care Trust. This remark was brought into conversation with me on more than one occasion by different nursing staff. Staff

15:44

felt that MAH was somewhat of an outlier and not necessarily wanted, due to these comments.

Oldstone Ward had a slightly different atmosphere. Oldstone was a resettlement unit located in the grounds of MAH and consisted of three or four houses which had their own bedrooms and kitchens and were not locked. Oldstone was used for those patients who were ready for resettlement, and assisted with the transition into the community. I didn't see MAH use the kitchens at Oldstone to prepare meals for patients which provided a sense of independence for the residing patients. 15:45 15:45

I did not have any contact with Cranfield ward and as such I am not in a position to comment on its atmosphere. My work consisted of supporting the older wards, namely Greenan, Ennis, Erne, and Rathmullan which were, in my view, institutionalised. The atmosphere was also significantly impacted by the respective Ward Managers who had overall autonomy for the day-to-day running of each ward. For example, certain Ward Managers would have been more helpful than others in terms of providing access and information in relation to patients, which would in turn either assist or hinder the resettlement process. I cannot recall the names of Ward Managers given the passage of time. 15:45 15:46

I do recall two staff nurses, H849 and H884, who were brilliant at their jobs and worked on the Erne and

Ennis wards. I remember significant numbers of agency staff come into MAH in the evening. However, they were not specialist nurses and may not necessarily have had the skill-set to deal with such complex patient needs and certainly would not have had sufficient learning disability experience. This appeared to be an ongoing issue. However, I did not witness any difference in approach between the wards to which I had access. 15:46

During my time at MAH, I witnessed good care, e.g. staff members who were always very attentive to the patients. H849 arranged transport to support a sensory integration therapy programme for a patient at a local park. On other occasions, staff worked on a programme to trial the use of showers rather than baths for patients on certain wards to support the transition into community living for individuals, and offer choice for patients. 15:46 15:47

I always felt supported in my role at MAH. Firstly, I worked with Dr. Shelley Crawford, who was exceptional in her field and assisted me with any queries I might have had in relation to the resettlement process. We worked together on each ward, beginning with Rathmullan Ward, with the purpose of resettling all the patients. Aisling Curran, Head Occupational Therapist Mental Health and Learning Disability, offered excellent professional supervision and support. Aisling Curran was based in the Belfast Trust, and visited MAH 15:47 15:47

regularly to discuss my progress on the resettlement programme. On a day-to-day basis I would liaise with H290, the resettlement manager in MAH, in respect of any issues on site, and liaise with Aisling Curran with any professional issues regarding the resettlement programme.

H290 knew the nurse managers, and it was her role to escalate any issues within the wards to her respective line manager. H290 sat at the same level as a Nurse Manager, which was above the level of a ward manager. H290 had stepped away from a nursing post to take up a new role as part of Belfast Trust's resettlement process.

MAH had been undertaking the resettlement process with no input from occupational therapists in the hospital or community to support those individuals transitioning from long stay wards, a role essential to sustain long-term community placement for people with complex needs.

I was employed by the Belfast Trust to work at MAH for a fixed period of three years, so it was easier for me to raise concerns to management regarding practices in the hospital. Other permanent members of staff reported it challenging to raise concerns for fear of the impact of this on their own career progression. While I raised concerns as listed above, I was not

privy to how the staff were disciplined, including the auxiliary nurse at Greystone Support Centre who had presented food in a roasting tin.

There were indications of an institutionalised culture at MAH, things like patients coming out of their room in the morning all wearing the same hospital sleep suits instead of individual pyjamas; light switch operated by staff keys instead of patients having access to their own lights; all patients leaving the ward to go to 'work', which was group day care, each day. 15:49 15:49

In terms of hospital admissions, I would have been made aware of the reasons for each inpatient admission by the senior management of MAH, and provided an opportunity to review the patient's notes. The patient's we were working with were long stay patients who had been admitted many years previously. Notes were often scant from admission, and history of patient's notes and information from other involved staff, such as speech and language therapists or care managers, were also used to inform a resettlement plan developed with patients. 15:49 15:50

Families were actively involved in the resettlement process, and this was appropriate. Family involvement was key to the understanding and provision of appropriate homes for any patient to be resettled into 15:50

the community. In certain circumstances, families may not have been very happy with the resettlement into the community. However, family involvement was necessary. For example, certain families may have felt that the patient would be better cared for in MAH and a move into the community could be detrimental to their future care or development. 15:50

Similarly, some families would have been aggrieved if their family member had resided in MAH for 50 years and was now being resettled into the community. My experience is that families were often grateful for my involvement in the resettlement process and appreciated that I was working in each patient's best interests. Ultimately, an increased focus on resettlement was the direction and strategy taken by MAH during 2012 to 2015, and this strategy had been signed off by the health minister at the time. I felt that families were confused by the sudden shift of moving patients back into the community, particularly when some patients had spent the majority of their lives at MAH, which could have been decades. 15:51 15:51

In terms of accessing patients' information, when I joined MAH in 2012, I had to start from scratch, i.e. had no prior knowledge of the patients. I was given access to patients' notes when required, although the years 1940 to 1970 notes were particularly scant as notes kept during this period were minimal. 15:51

My role at MAH as an occupational therapist was to undertake a holistic assessment of each patient. This included an assessment of functional, social needs, sensory and mental health needs in order to create an appropriate treatment plan. Initially, these were 15:52
baseline assessments as nothing had been conducted previously. Initially, all notes were recorded on hard copy paper. However, towards the end of my time at MAH, patient notes were recorded on the online system known as PARIS. From that point in time, all MAH 15:52
patients received a new electronic care record. Each patient received an assessment along with proposed interventions and a written report.

Assessments and treatment plans included sensory 15:52
integration or functional assessments. I would not have included a positive support plan or directed an intervention such as cognitive behaviour therapy or CBT.

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Supervision of meals depended on individual needs, and each patient was provided with assistance or supervision as and when required. Speech and language therapists would often have attended meal times if there was a choking risk, also known as dysphagia. 15:53

In relation to restrictive practices, I was aware of the practices insofar as they were recorded in the patient notes or if I was notified from time to time by

the MDT. In practice, any restrictive practices relating to patients should have been recorded in the patient notes. Dr. Shelley Crawford and I introduced restrictive practice guidelines in accordance with the Belfast Trust to ensure that restrictive practices, mainly in relation to seating, was conducted in line with legislation. 15:53

Dr. Shelley Crawford was the expert in restrictive practice protocol, and I would not do anything without her input. I would have been responsible for seating and showering for individual patients. On some occasions, this may have required the use of a belt for safety, for example during showering. This practice, which I would have conducted in line with the Belfast Trust protocols, the restrictive practice would be agreed with the multidisciplinary team and the document would be countersigned by a consultant and usually nursing staff too. A copy was kept in the patient's file and my occupational therapy notes. 15:54 15:54

At times, patients became distressed and I would have considered the use of various interventions to de-escalate that patient. The type of intervention used would depend on the level of distress experienced by the patient and the nature of the patient's disability. For example, a common intervention would be to remove the patient from a certain situation into a safe place and away from the area of distress. For more severe levels of distress, the relevant medical 15:54

professional would consider introducing medication. I was not responsible for administering medication, instead this would have been carried out largely by the nursing staff. I was not required to manage much distress at MAH and, as such, I cannot recall any specific incidents or names. I was not trained in the Management of Actual Or Potential Aggression, or MAPA, but had some low level training during my time at MAH. In the event that MAPA was required, I would have relied on nurses who were trained in MAPA. 15:55

I did not have any issues around the delivery of restrictive practices at MAH and did not see restrictive practices take place very often. However, I did get the impression that there was a lack of awareness regarding the restrictive practice procedures, particularly regarding the Belfast Trust protocol in relation to seating. When I arrived at MAH in 2012, I wasn't aware of a staff member having received training in relation to seating and restrictive practice, and this caused difficulties in certain circumstances. For example, patients were strapped into chairs and they could not get out, which was inappropriate for many of those patients. I supported Dr. Shelley Crawford in educating staff, introducing protocols to prevent any future misuse of seating belts. 15:55 15:56 15:56

During my time at MAH, I did not witness any use of

seclusion as I was not often on the wards where seclusion rooms were used. If seclusion was used, I am not aware of where the patients would have been taken. I understand that on one occasion, a patient was placed in a room due to his erratic behaviour and that this was a decision taken by the consultant and nursing staff at the time. 15:56

A separate issue identified by Dr. Shelley Crawford related to patients' use of wheelchairs. She discovered that many individuals were paying for their own wheelchairs. However, as an occupational therapist in the Belfast Trust, she was able to find a budget to order wheelchairs at the cost of the Belfast Trust. It was inappropriate that patients were required to fund their own chairs. 15:56 15:57

In respect of CCTV, I was not aware that this function was available during my time at MAH between the years of 2012 and 2015 and, as such, I am unable to comment on the use of CCTV. 15:57

My focus at MAH was to assist in the process of discharge and resettlement. Many patients were ready for discharge. However, the difficulty for MAH was finding a suitable home for the patients to resettle. 15:57 Significant time was spent assessing the functional, physical, sensory and mental health needs of patients. These assessed outcomes informed the various spacial accommodation requirements for each patient in the

community. In addition to the physical infrastructure needed, I assisted MAH in the social infrastructure required for community living also, particularly for patients with significant sensory and learning disabilities. It was not enough simply to send patients into the community, as they required a support network, care providers who knew them, and time to become familiar with new surroundings. During this process, I worked with NIHE, the Belfast Trust, third party charitable entities such as Community Roots and L'Arche for learning disabilities, in addition to working with professional colleagues. 15:58 15:58

During my time at MAH, I also undertook a Master's in advanced clinical practice at Ulster University." 15:58

The witness then goes on to describe some details of that. Moving to paragraph 43:

"In my experience, care on the wards was always patient-centered. On a regular basis, I would have provided feedback to staff and this would have been recorded in the patient notes. For example, if there was a specific occupational therapy need, this would have been shared with nursing staff, and I would have provided the requisite information for implementation. The assessed need would have also been discussed at weekly ward meetings, and particularly relevant to agency staff who joined MAH with no background 15:58 15:58

knowledge of the patients. One patient, for example, needed to spin to regulate his behaviour, and in order to spin we required sufficient time and space. This was fed back to the nursing staff and MDT generally.

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The staffing appeared to be sufficient at MAH but mostly made up of nursing auxiliary staff. I did not get the impression that MAH was understaffed, although agency staff did appear to come in more towards the end of my time there. There were no psychologists on the ward, which was a significant omission in terms of professional staff. On occasion, speech and language therapists would have visited MAH to work with the patients as and when there was sufficient funding to do so.

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There was significant corrective work to be carried out for seating and positioning in bed and in seats. Seating passports were placed on chairs to ensure that patients were comfortable and placed on correctly adjusted seating. I supported my colleagues in seating assessments that required two people to assess.

16:00

Nurse managers would have been responsible for the auditing of care plans. I am aware that occupational therapy notes would have been audited on an annual basis. Any feedback in relation to the occupational therapy notes would have been general, e.g. not to use abbreviations or minor syntax recommendations. Given

16:00

the passage of time, I do not recall any specific examples. I am not aware of any specific changes to the occupational therapy care plans as a result of the audits.

16:00

I was not responsible for monitoring the use of PRN sedation, restraint and seclusion on the ward and, as such, I cannot comment."

The witness then goes on to express her preferences in terms of giving evidence to the Inquiry, and completes the declaration of truth, signing her statement on 22nd April 2024. 16:00

CHAIRPERSON: Thank you very much. Thank you to both of those witnesses that have been read this afternoon, and the Inquiry, of course, will be writing to them to thank them. 16:01

All right. I think we've got three witnesses tomorrow. 16:01

MS. TANG: That's correct, Chair.

CHAIRPERSON: I don't know if you're calling any of them.

MS. TANG: I will be calling the witness in the afternoon. 16:01

CHAIRPERSON: Okay, excellent. We'll sit at 10 o'clock tomorrow. Thank you very much, everybody, for their attendance. We'll see you tomorrow.

THE INQUIRY ADJOURNED UNTIL 10:00 A.M. ON WEDNESDAY, 5TH JUNE 2024