MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON TUESDAY, 10TH SEPTEMBER 2024 - DAY 101

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

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GWEN MALONE STENOGRAPHY SERVICES

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THE INQUIRY RESUMED ON TUESDAY, 10TH SEPTEMBER 2024 AS FOLLOWS:

CHAIRPERSON: Thank you. Ms. Briggs.

MS. BRIGGS: Good afternoon Panel. Your witness today is H112, a former nurse and senior nurse at the hospital, and the statement reference is 276. 13:54

Chair, you had made a Restriction Order, that's No. 80 in relation to the witness, and the witness is to be referred to by her cipher. 13:54

CHAIRPERSON: Okay. Thank you very much indeed.

MS. BRIGGS: Unless there's anything further, Panel, we can call the witness.

CHAIRPERSON: No, let's get the witness in. 13:55

H112, HAVING BEEN SWORN, WAS EXAMINED BY MS. BRIGGS AS FOLLOWS:

CHAIRPERSON: Good afternoon. Thank you very much for joining us. You and I have just met very briefly in the witness room, and I'm just going to repeat what I've said to you. First of all, thank you for coming to assist the Inquiry. The first few moments are always a bit anxious making, but all witnesses will get into the rhythm, we've found, very quickly. 13:55 13:56

A. Yes.

CHAIRPERSON: If you do want a break though at any stage, just give me a nod, as it were, and we'll stop

for a bit. All right?

A. Okay. Thank you.

CHAIRPERSON: And I'll hand you over to Ms. Briggs.

1 Q. MS. BRIGGS: Thank you, Chair. H112, good afternoon. We've met earlier today, and as you know I'm going to be asking you a series of questions about your statement that you've made for the Inquiry. And I've explained to you already that if you'd like to refer to someone by name, please have a look at the cipher list in front of you, and if it's not there, please indicate to us and we'll help you. Okay? 13:56 13:56

Your statement reference is 276, you have a copy of it there in front of you, and it's on the screen as well, and it runs to 36 pages. Are you content to adopt the contents of that statement as your evidence to the Inquiry? 13:56

A. Yeah, I'm content.

2 Q. Now I've explained to you that I'm not going to read the statement out loud, okay, the Panel has it and the Core Participants to the Inquiry have it as well. Okay. And I've explained to you that I'm going to spend proportionately a lot more time on the first half or so of your statement than the second half. All right? And I'm going to go to specific things that you say there and take you to those as we go along? 13:57 13:57

A. Okay.

3 Q. All right. So just for background, it's correct to say that you worked as a nurse at Muckamore for 18 years,

isn't that right?

A. That's right, yeah.

4 Q. And that was between 2001 and 2018?

A. Mhm-mhm.

5 Q. Isn't that right? 13:57

A. Yeah.

6 Q. Okay. And you came to Muckamore right after you obtained your learning disability degree at Queen's - nursing degree at Queen's?

A. Ehm, yeah, a diploma. 13:57

7 Q. Diploma. All right. So at paragraph 5 of your statement, if we can pull that up on page 2, you set out there a list of all the wards that you worked on, what dates you worked on them, and what band or grade of nurse you were at that time? 13:58

A. Mhm-mhm.

8 Q. Is it fair to say as a summary that you worked across a variety of wards during your time at Muckamore and that they were both core wards and resettlement wards?

A. Yeah, that's correct. 13:58

9 Q. Would it be fair to say that perhaps more time was spent on the resettlement wards?

A. No, possibly -- well, I suppose I feel majority of my time was spent on the core hospital wards. I had a very small part of my career in the resettlement wards. 13:58

10 Q. Okay. Well what we'll do later on is we'll pick up on the differences, because you describe them very well in your statement between the core hospital and the resettlement wards. All right.

A. Yeah.

11 Q. And you finished your career in Muckamore as a Band 8A Service Manager, and that was in 2018, isn't that right?

A. Ehm, no. I went back to a Ward Sister role before I left and then took a secondment to SPPG. 13:58

12 Q. Okay. So you finished as a Ward Sister, that was after you were a temporary -- a Service Manager?

A. Yeah.

13 Q. Okay. And then you moved on after that? 13:59

A. And then I moved on, yeah.

14 Q. Okay. You tell us over the page then at page 3, paragraph 6, that you chose to work at Muckamore after your diploma, as you viewed it as a good place to work. Can you tell the Inquiry a little bit more about that? 13:59

A. Yeah. I suppose during our training you had various placements as a student nurse, and I suppose lots of professional people that you would have met along the way would have said things like "Oh, it's really good to work in Muckamore. If you can work there, you can 13:59 work anywhere because it's quite a challenging environment", and it's quite difficult to work in in-patient services, so it was definitely deemed as an opportunity to gain really good experience across the board. 13:59

15 Q. Right. I'm just going to ask you to speak just a little bit slower just because the stenographer will be taking a transcript. All right. You go on to tell us about the wards that you worked on in the early days,

okay, if we put it that way, and that was Greenan Ward in 2001 and then Fintona North until 2006.

A. Yeah.

16 Q. And you're positive about your experience on Greenan.

A. Mhm-mhm. 14:00

17 Q. If we can go down to paragraph 9 on page 3, you're describing Fintona North Ward.

A. Mhm-mhm.

18 Q. And towards the end of page 3 and into page 4 you say this, you say: 14:00

"It was very different from Greenan Ward and there was a large nursing team. However, there were only two day rooms in the ward and these were overpopulated. There were around 15 patients in one day care space and then 14:00 seven patients with more profound needs in the other room. There were two to three nursing staff to look after 15 patients."

A. Mhm-mhm. 14:00

19 Q. You say that the day rooms were overpopulated. How many patients do you think would have been an appropriate number in those two rooms?

A. I suppose it's kind of hard to articulate. Back then it probably, you know, it was a long time ago, it 14:01 probably felt that that was appropriate. The environment was just a large room. It wasn't segregated into smaller sitting rooms, so it wasn't really conducive, you know, to a therapeutic

environment. 15 was a lot of patients, I suppose. It's more if you look at it in terms of staff ratio I suppose is how you would answer that question. Possibly two or three staff wouldn't have been appropriate to look after 15 patients. Perhaps if you had more staff within that environment that might have made things a wee bit more safer. 14:01

20 Q. How many more staff do you think might have made it safer?

A. Ehm, possibly six or seven, I suppose, with a staff ratio of, you know, one person looking after two patients. 14:01

21 Q. So you think six or seven staff across those two rooms rather than the two to three?

A. Yeah. Yeah. 14:02

PROFESSOR MURPHY: Were a considerable number of them out at day care during the day?

A. There would have been patients out at day care, yes. Although Fintona North was an admission ward, so there would have been periods of time where they wouldn't, you know, when patients would have came in you had to assess them and get to know them, and they wouldn't have had day care straight away, so they wouldn't have had full-time day care either, I suppose, possibly some patients would have had four or five sessions per week, so that might have been five mornings. 14:02

PROFESSOR MURPHY: A session being half a day?

A. Yeah.

PROFESSOR MURPHY: Thank you.

22 Q. MS. BRIGGS: You describe in your statement how Fintona North, and it's a female challenging behaviour ward, you say it was a challenging but positive environment, you say that towards the end of paragraph 9.

A. Mhm-mhm. 14:02

23 Q. And at the start of paragraph 11 on page 4, you describe how care plans assisted in de-escalating the patient's challenging behaviour.

A. Mhm-mhm.

24 Q. I'm going to ask you about the use of care plans and 14:03
other nursing records. To what extent would the nursing records include the likes of structured activities for patients on the ward?

A. Yeah, they would have very much detailed structured activities. I suppose back then the nursing model 14:03
would have been Roper, Logan and Tierney. So that was where you assess patients into I think, if memory, 15 activities of living, and one of those activities of living would have been a patient's social needs. So under that category you would have assessed the 14:03
patient's need about their socialisation and structured activities. So that would have formed very much part of their care plan.

DR. MAXWELL: So if I had arrived as a new nurse on the ward, I could have looked at the care plan and seen 14:03
which structured activities a particular patient was to have that day, would I?

A. Yes, it would have been recorded within the care plan, and then there would have been an activity schedule

available within the ward in terms of the range of activities available to all patients.

DR. MAXWELL: And if I -- if the patient was staying on the ward, what sort of social, what sort of structured activities would they be engaged with? 14:04

A. It would have been like tabletop activities, like jigsaws, board games. Fintona North, I suppose because it was a female ward, there would have been lots of hairdressing, make-up, nails, there would have been -- there were young girls with learning disability, and 14:04 that would have formed very much part of their social needs, and they would have enjoyed that. Foot spas, out of memory, would have been very popular.

25 Q. MS. BRIGGS: H112, later in that paragraph at paragraph 11, you're discussing seclusion. 14:04

A. Mhm-mhm.

26 Q. And you say that there were a small number of patients for whom seclusion formed part of their care.

A. Mhm-mhm.

27 Q. You say that you cannot recall receiving training over 14:04 the use of seclusion in or around 2001, and you say that it was a learning curve, but there was a seclusion policy in place and you were guided by senior staff members on the ward?

A. Mhm-mhm. 14:05

28 Q. Would you have expected to receive training in seclusion in and around that time?

A. Ehm, well, perhaps not seclusion. I suppose people have different opinions in relation to restrictive

practice. I suppose people -- back then the Trust would have trained you on physical intervention, which perhaps at that point in time would have been called MAPA. So you were always trained in how to use physical restraint, which then possibly would have led to seclusion, so that formed a wee bit of your training. I suppose I always was an advocate for a least restrictive approach, and for many years I felt it would have been more prudent to train you on Positive Behaviour Support, so to have more positive engagement rather than the restrictive end where you're ending up in seclusion. 14:05 14:05

29 Q. Do you think more specific or directed training in seclusion itself might have been of assistance?

A. Well, I suppose the seclusion policy was very much a guide on the operational process on how to seclude somebody, and that the authorisation process of, you know, who authorises it, at what point do you lock the door, what numbers to ring, and to do Datix forms? So all the paper work that's involved around seclusion. But I suppose things like Positive Behaviour Support would have supported more evidence based, would have supported your decision making at what point people required seclusion. But back in 2001, I suppose there maybe wasn't the evidence base there to support decision making, so you were very much guided on the senior nurses on the ward who were more experienced than myself when I first would have started. 14:06 14:06 14:06

CHAIRPERSON: And how -- you say you were an advocate

for PBS.

A. Mhm-mhm.

CHAIRPERSON: How was that received? Was there much PBS going on when you arrived on the ward, and how was it received when you advocated for it? 14:07

A. I suppose not in 2001, no, there wouldn't have been. You would have had support from behaviour services, so some behaviour nurses on the site who would have came to support you with more complex people who were very challenging, and they would have supported you on how to best manage them during a crisis. But, no, it certainly wouldn't have been a huge feature in 2001. 14:07

PROFESSOR MURPHY: So did you eventually have training in PBS?

A. Yes. Whenever I was the Ward Manager in Donegore Ward, I can't recall if PBS was -- I don't completely remember if it was the direction of travel from the Belfast Trust as such. 14:07

PROFESSOR MURPHY: So you had it in MAH, it wasn't that you went externally for it? 14:07

A. No. Well, when I say you have it in, you know, your courses would have been commissioned through the CEC, so you would have contacted providers who would have provided you with the education opportunities.

PROFESSOR MURPHY: So that would have been roughly what date when you were in Donegore? 14:08

A. Ehm, probably in around 2010/2011.

PROFESSOR MURPHY: Yes. Thank you.

DR. MAXWELL: Can I just ask, you said you hadn't had

any training on seclusion. When you did your diploma, was seclusion ever discussed? Both in terms of when it was necessary, but also the impact it would have on patients?

A. No, I don't recall. I suppose I did do a diploma in learning disciplinary nursing and then went on and done my degree and studied that part-time. I don't recall restrictive practice being a heavy focus of part of our educational programme, and perhaps it was, but I certainly don't remember it. 14:08

DR. MAXWELL: And during your placements...

A. Yeah.

DR. MAXWELL: Did you see much use of seclusion?

A. No.

DR. MAXWELL: So was this something fairly new? 14:08

A. Yeah, really new, yeah.

DR. MAXWELL: And you also went on to complete a degree in health studies in 2003. Was that specifically about learning disability?

A. No, it wasn't about learning disability, no. Back then there wouldn't have been a learning disability degree, so I went on and studied that part-time. It was more generic around health and health promotion and research and things. So just to get the degree. 14:09

DR. MAXWELL: At what point do you think learning disability nurses in Northern Ireland started to talk about seclusion in any professional fora? 14:09

A. I suppose around the time of the Deprivation of Liberty Guidance. When I was in Donegore I know that that

white paper came out and it was issued to the Trust at the time, and sometimes that information would have came out, but it wouldn't actually have told you what to do in practice, it would have just, you know, take cognisance of this might constitute restrictive practice. I remember, I suppose at that point in my career I felt a real change for me as the senior person on the site, and I tried -- I spent a lot time trying to understand what deprivation of liberty was, so that DoLS paper came out and I spent a lot of time researching it and trying to understand the implication for us in practice, and I feel this was probably around 2000, whenever I was a Ward Sister. Sorry, I'm just referring to my dates. Yeah. So probably 2011. I think that paper possibly came out in 2010. 14:09 14:10 14:10

DR. MAXWELL: Okay.

CHAIRPERSON: Thank you.

30 Q. MS. BRIGGS: If we can go to paragraph 12, it's the bottom of page 4. You say there at the third sentence that there was positive culture on Fintona North and within the large team of staff. You enjoyed coming to work as you felt very supported in your role. 14:10

A. Mhm-mhm.

31 Q. And you go on after that to describe H41, the consultant psychiatrist, and say that they knew every patient on the ward and they expected a high standard of care. How important was the input of the consultant psychiatrist for your work? 14:11

A. Yeah, it was crucial, I suppose to guide our practice.

That consultant, H41, was a particularly experienced consultant psychiatrist, and she had a lot of knowledge, and I suppose I was always shocked as a young nurse that she knew so many patients so well, because it was a large ward. So she would have been the clinical responsibility for say 18 to 20 patients, and she knew all of their needs very well, and she also knew them I suppose not just in terms of psychiatry, she knew their physical healthcare needs. So we would have had weekly multidisciplinary team meetings and that very much guided our practice as nurses. So we would have reviewed all patients at the multidisciplinary team meetings, and there would have been a case discussion and then actions coming out of it. So after the multidisciplinary meeting then, the charge nurse, or myself, whoever the senior nurse was at the time who attended them, would have came out and started to share that information with the nursing team and implement some of the plans of their care that was decided within the room. So the consultant psychiatrist was extremely important, particularly in a ward like Fintona North, because obviously the Mental Health Order was in use, there was people there that were detained, some of the service users would have went AWOL and absconded, so there was a lot of high risk behaviours, ehm, that you absolutely needed the support and guidance of the psychiatrist. 14:11 14:11 14:12 14:12 14:12

32 Q. Would you say it was an equal partner type relationship with the consultant psychiatrist or would it be that

nurses and healthcare assistants were deferential towards the consultant?

A. I suppose it depends what year you're asking me that. I suppose back then there probably was still the hierarchy, you know, around 2001, where consultant psychiatrists were seen very much on a pedestal or like God-like figures, do you know. People had a lot of respect for them, and I suppose as a young nurse you might have been a wee bit intimidated by them. But as time went on there was absolutely equal partnerships, and I suppose it was a more, I don't know, the consultants became a wee bit more relaxed in their interactions with nurses. 14:12 14:13

33 Q. Okay. And you've spoken very positively about H41 and the impacts that H41's knowledge and experience had for your time there. 14:13

A. Mhm-mhm.

34 Q. Was that the same with other consultant psychiatrists across your time at Muckamore in the various wards that you worked at? 14:13

A. Yeah. I mean, I had quite a positive experience with all consultant psychiatrists. I suppose for a large part of my career in Muckamore I was quite a senior person, I suppose particularly in a Ward Sister role, that was a very important role, and I suppose depending on how often the consultant psychiatrist was physically in your ward, that relationship would have varied. So I feel, yeah, you'd have been in equal partnership with the consultant psychiatrist and they absolutely would 14:13

have respected me as a professional. But I suppose depending on what ward you've been in or how they depended on me more so I suppose for knowledge because they maybe wouldn't have been as visibly present as other psychiatrists would have been.

35 Q. And that's obviously speaking as a Ward Sister, there's more perhaps of an equal partner type relationship and this mutual reliance. Would you say that for other staff on the ward who weren't as high a level as you were, did they -- how did they feel about the consultant psychiatrist? Was it more of a consultant is in charge and everyone else is less senior, or was it more an equal partnership for them as well?

A. I suppose I feel I suppose, and I know you're coming on to that, about the core hospital and resettlement wards, so I suppose -- lots of the staff would have known the consultant psychiatrist, yeah, and they would have known even, like the Band 3 staff and the domestic staff, they would have known them by name, which is really important, you know, in terms of leadership, that the consultants know everybody and can contribute to the team. But there definitely would have been more visible lead present in the core hospital wards, so perhaps in the resettlement wards the consultant psychiatrist might not have known your staff team as well, because they wouldn't have been present as much.

36 Q. You go on, H112, to tell the Inquiry about your time on Finglass Ward for a few months in 2006, and you're a Band D.

A. Mhm-mhm.

37 Q. And then 2006 to 2009 you worked in the core hospital?

A. Yeah.

38 Q. On Cranfield Men's Ward. We're at paragraph 15 on page 5.

A. Yeah.

39 Q. You describe there in the third sentence how PICU was linked to the Cranfield Wards by a corridor, and you say that because there was no Ward Manager for PICU the Cranfield Men's Ward Manager would rotate and was also responsible for PICU?

A. Mhm-mhm.

40 Q. Why was there no Ward Manger on PICU?

A. I suppose my understanding of it would have been initially perhaps to think it might have been it was a small six-bedded unit that didn't require that high level of senior staff in it, that perhaps it was only six beds so therefore it could be supported by the adjoining wards.

41 Q. Do you feel that it was sufficiently supported by the adjoining wards, that is to say Cranfield?

A. I think it was probably the wrong decision, that it absolutely would have needed its own Charge Nurse or Ward Sister, which they got later on - I'm not sure what time that happened. But the people coming in to PICU were our most unwell patients. So if some patients would have been really unwell or been in maybe Cranfield and transferred up to PICU because they became unwell, so they were your most complex,

challenging, very unwell patients, so they absolutely probably should have had that senior level in terms of leadership to support the care delivery.

42 Q. Towards the end of paragraph 15 at the bottom of page 5, you say that during your time in Cranfield you say: 14:17

"I found it to be a good ward to work in and an exciting time for Muckamore as we had moved to the new wards in the new building with a new model of care. This greatly boosted staff morale and lots of people 14:17 wanted to work there."

A. Mhm-mhm.

43 Q. How did the new model of care differ to the old model of care? 14:17

A. Well, I suppose I do refer to that in my statement. The model of care didn't really change, I suppose. Whenever we went to work in the core hospital wards I suppose I felt probably we were going to be these highly skilled staff and we would get additional 14:18 training because we were moving to a new model, but the reality of that was we were actually just changing environments to a more appropriate and a more therapeutic environment. There was no additional training for staff. And I remember being disappointed 14:18 about that as a young nurse, because you were excited about the future and you thought "Oh, I'm going to be really skilled and I'm going to get all this additional training." Probably back then I didn't know what that

training would look like, but it was an exciting time because you thought you were going to work in this new model, but actually you were just going to work in a really lovely, bright, vibrant ward, which absolutely did support the delivery of care and make it more positive. But there was -- in my opinion there was no new model of care.

44 Q. So the building changed but nothing else really changed, is that your evidence?

A. Yeah. Yeah. 14:18

DR. MAXWELL: But was there supposed to be a new model of care? You've said there wasn't one in practice because nobody got any training to do anything differently, and you referred earlier to starting to learn about Positive Behaviour Support in around 2011, so this would have been similar-ish time. 14:19

A. Mhm-mhm.

DR. MAXWELL: Was there supposed to be a different philosophy of care in the core hospital?

A. In my opinion, yes, because we were moving away from institutionalised care and institutionalised buildings and we were moving towards an assessment and treatment model. So I would have assumed that the model of care would have been very much focused on assessment and treatment. 14:19

DR. MAXWELL: So you were expecting a different philosophy of care?

A. Yes.

DR. MAXWELL: Even though in practice that didn't

happen?

A. Yeah.

DR. MAXWELL: Did any staff get any information about what this new philosophy of care would be?

A. I don't completely recall. I remember being -- having maybe like welcome sessions or information sessions being held on the site for the staff that were going to work in it to go and meet with the senior managers, and they would have told you a bit about it, but I can't totally recall what that looked like. 14:19 14:20

DR. MAXWELL: Because one of the things we've heard actually from some other witnesses is that actually it became more clinical and hospital like, because in the old wards, even though they weren't in great repair they were more homely, whereas the core hospitals felt like an acute hospital ward and weren't as personalised. 14:20

A. Yeah.

DR. MAXWELL: And that suggested more of a medical model of care rather than a psycho-social model of care. Did you feel that? 14:20

A. No. I mean I totally agree, yes, it wasn't a homely environment, but I feel that's a positive. I feel that was good that we were moving away from a nursing home feeling in wards, and, yeah, it wasn't homely. But I suppose we had lots of whiteboards, which I'm obsessed with, but we would have used them a lot to try and personalise somebody's bedrooms and then put photos up of their families and information for patients. So, 14:20

yeah, it won't homely, but I feel that that was a good thing. I don't feel a medical model, no.

DR. MAXWELL: So you didn't think it was a medical model, but maybe not being homely reinforced the fact it was only for assessment and it wasn't a place for life. 14:21

A. Yeah. Yeah.

45 Q. MS. BRIGGS: I'm going to move on to the next part of your statement. In 2009, H112, you go to Donegore Ward. 14:21

A. Yeah.

46 Q. As a Band 6 Deputy Ward Sister. And this is also a female challenging behaviour ward. You go on in your statement to describe how there were around 20 members of staff, mostly Band 5s and Band 3s, and that's at 14:21 paragraph 20 on page 7, it's the third sentence into that paragraph. Because Donegore was a challenging behaviour ward, did the ward staff receive any additional training around challenging behaviours?

A. I don't recall the staff receiving specific training, I 14:22 suppose, when it opened, at the start of the opening of Donegore. Donegore opened up much later than the first phase of the core hospital, so it opened later. I don't recall them having specific training, albeit there was psychologists employed to work in the ward 14:22 for a short period of time, and I suppose the ethos back then was possibly it was a psychological model.

47 Q. Would it have assisted to get that type of specific training?

A. Yes, we had put -- I suppose moving on, and I suppose we did have training, and we would have Positive Behaviour Support training, and there was other additional training that I would have organised myself as a Ward Sister to support the care delivery in that ward. But I just, I can't recall if we done some of the training before it opened, you know, as part of the direction of travel for that new ward. 14:22

48 Q. Okay. But training did subsequently happen?

A. Yeah. 14:23

49 Q. As time went on.

A. Yeah.

DR. MAXWELL: Would the healthcare assistants have had training about this new philosophy of positive behaviour support? 14:23

A. Absolutely. I suppose in Donegore we -- I have to say during that time period the staff team was absolutely fantastic, and the care -- the Band 3s provided amazing care within that ward. I suppose the patient, it was quite a challenging ward to work in, and I would have arranged KUF training and other training to help support people with personality disorders. 14:23

DR. MAXWELL: Sorry, you would arrange something training? It sounds like KUF?

A. KUF. I can't remember what it stands for. 14:23

DR. MAXWELL: But what was it in essence?

A. It was training. I contacted the CEC, the education providers, to seek out additional training to help the staff team support somebody with personality disorder.

So it's quite challenging to look after people with learning disability and personality disorder, and it was a difficult time for the staff team to try and deliver that care, so I sought out additional training, and there was two bespoke training sessions that they ran for the whole entire team, all grades of staff.

DR. MAXWELL: And CEC is the Clinical Education Centre that's run as part of the health system in Northern Ireland.

A. Yes. Yes. 14:24

50 Q. MS. BRIGGS: You say you sought out that training?

A. Mhm-mhm.

51 Q. Was that an idea that you had come up with yourself? It hadn't come from the levels higher than you?

A. No, definitely not. It wasn't mandatory training. I sought it out because staff were struggling to support this service user appropriately, and they were very honest about that, about their challenges and things that they found difficult. There was a high level of incidents in the ward with that particular service user, so I contacted the CEC to see what -- if there was any courses that they could support our team. 14:24

52 Q. And that's a theme that is throughout your statement really, it's the need for initiative in leadership, is that a fair way of putting it? 14:24

A. Yeah. Yeah, that's fair.

53 Q. And that's an example of when you took the initiative as a leader?

A. Yeah.

54 Q. Okay. We're still on paragraph 20. You describe there how you became the Ward Sister on Donegore and you stayed in that role until you moved on from Donegore in 2016.

A. Mhm-mhm. 14:25

55 Q. And you're describing at the end of that paragraph how the RQIA described Donegore as a centre of excellence under your leadership after an inspection, and that the ward won multiple service improvement awards. How did positive recognition of that type affect or influence 14:25 staff morale on the ward?

A. Oh, it was fantastic. I suppose it's one of my many happy memories out of my whole career, my time spent in Donegore. I suppose that recognition was not about me, it wasn't me personally, it was about the recognition 14:25 of the whole entire team who collectively worked really hard every single day in a very difficult environment, but they were very committed to the care delivery, they were very committed to me, and it wasn't without its challenges. I suppose I am obsessed with leadership 14:26 and patient centred care, but with that can be particularly challenging when you're asking a staff team to not use physical intervention in your ward with patients that are extremely challenging. But they, I suppose, supported me and embraced the care delivery in 14:26 the model that I wanted, and the ethos in the ward, and they were very proud of their team, very proud of the awards that we won, yeah.

56 Q. And does that pride, does that influence or effect the

care given to patients in any way?

A. Oh, absolutely. Absolutely. I mean happy staff, happy patients. The staff team were so proud of the care. They loved coming into their work. We always had millions of initiatives. They were coming up with ideas to make the care better. They were wanting - coming up with ideas, like Band 3s coming to me wondering can we run, you know, a cookery programme. 14:26

57 Q. I'm just going to stop there because you've used a name there. 14:27

A. Sorry.

58 Q. You're okay. We'll just take a quick pause. You were describing there how it affected the staff and the patients on the ward winning those awards and so on and so forth. If we just pick up with what you were saying there? 14:27

A. Yeah. The staff were I suppose creative and full of ideas. They really contributed to the care. The communication in the ward was fantastic, you know, regular staff meetings, regular patient forums, and we worked in partnership with patients in that ward, and the staff definitely were compassionate and took pride in their work. 14:27

59 Q. Okay. Thank you. You've touched upon it there in your last answer, and you also mention it in your statement that during your time on that ward there was no physical intervention used. Can you describe how ward staff were able to manage the challenging behaviours of patients without the use of physical intervention? 14:28

A. Yeah. I suppose they were able to -- it took a long time, I suppose, to -- it was really around the Deprivation of Liberty Guidance, I tried to use that as a service improvement project for the ward. So we had regular working groups with all grades of staff about -- to see what we understood to be deprivation of liberty. I felt it was important that we educated the staff first so that they understood what restrictive practice was. We also educated them with the PBS training. I think I'm pretty sure it was potentially e-learning at the time. So all the staff team had the Positive Behaviour Support training, coupled with -- they formed part of my restrictive practice working group. Then with care documentation, I devised as well that we really personally assessed each and every individual in relation to their restrictive practice that was used on the ward, enabled then the staff to deliver a least restrictive approach, which involved lots of things, I suppose most importantly working in partnership with patients, that the patients were directly involved in the care, that the patients attended the multidisciplinary team meetings, which wouldn't have happened back then, that was quite unusual that the patients would have came to the ward rounds. We would have used good use of the physical environment to nurse patients then, that they weren't all sitting on top of each other and congregating in one area.

14:28 14:28 14:29 14:29 14:29

CHAIRPERSON: Sorry, did you just say the patients

would come on the ward rounds?

A. Come into the ward rounds, yeah.

CHAIRPERSON: And how would that work?

A. They would have been invited to attend. We gave them an opportunity to attend the ward rounds. The ward rounds would have happened once a week and they would have came into ward round to have a discussion at the end so that they could contribute to the care, or if there were decisions made about them, then we would have -- the team would have been able to tell the patient the outcome of some of the things that they would have asked to be discussed. 14:30 14:30

CHAIRPERSON: Right.

DR. MAXWELL: But they only came to the discussion about themselves? 14:30

A. Yeah.

DR. MAXWELL: They didn't discuss other patients?

CHAIRPERSON: As opposed to wandering around --

A. Oh, yes, sorry. No. Yeah. We would have structured their times so that they came in individually on a one, you know, to meet the team and have discussions. So, yeah, there was a high level of therapeutic engagement in that ward, and I still believe to this day it's the only way that you can reduce any form of restrictive practices, that the patients are therapeutically engaged. So we would have had really structured days every day, a high range of activities. We created a social club for patients where staff would have came in in their own clothes, I suppose to try and support 14:30 14:30

engagement and get the patients to have buy-in and wanting to participate in the activities, when they seen some of the staff coming in without uniforms on that they were coming in specifically to do this club or to do a task, it really supported them in terms of their participation.

60 Q. MS. BRIGGS: Right. Later on in paragraph 21, you describe the ward being the first in Northern Ireland to use an outcome tool called the Health Equalities Framework, and you led the pilot for it, and it's aim was to determine how to improve the quality of life for service users, and you describe that in your statement. You go into detail about how it worked and how it was piloted on Donegore. After the pilot period, was the model kept in place in Donegore? 14:31

A. I suppose I can only speak on the time that I was in Donegore. I believe that it was kept in place during the period that I was there, and then I was moved wards to Moylena, so I'm not sure that it remained. I don't believe that it possibly did. 14:32

61 Q. Was it used in other wards after the successful pilot?

A. Ehm, not that I'm aware of. I think possibly later there was a bit of chat on-site about trying to reintroduced HEF. I'm not sure what time period that came about, but there was trying to implement it again. 14:32 I think one of the challenges was that you needed staff that were trained in HEF, and actually I was the only one that was actually trained do it, so that would have been a huge resource issue.

CHAIRPERSON: But presumably if that had a good effect, which you thought it did, did you go to your managers and say 'look, I really think this should be rolled out"?

A. Yes, I did, yeah. 14:32

CHAIRPERSON: And what was the reaction to that?

A. I suppose I don't feel -- I suppose I was the one that was delivering the training, I suppose, in terms of HEF. It was a fantastic tool, but it required me personally to work very, very hard. It was an outcome 14:33 measurement tool that had never been used in in-patients before, so it came from consultant nurses in England, and they would have used it in the community. So we were the first people to use it in in-patients, which required me personally to then train 14:33 every single one of my staff members. There was no training support for me, there was no people coming in to support the staff. There was lots of challenges to it in terms of multidisciplinary input. It wasn't a nursing tool, it was an outcome tool that was to be 14:33 used for all multi-professionals, so I tried to use it at the ward round, us as a group of professionals would use --

CHAIRPERSON: Slow down. Slow down.

A. I know. Apologies. I speak really fast. 14:33

CHAIRPERSON: I've noticed. If you could just take it a bit slower.

A. Sorry.

DR. MAXWELL: But you do say that Molly Kane, who was

the LD nursing lead at the PHA, had worked with you on this. Presumably she saw the effect it was having, you were giving her feedback about how effective it was.

A. Mhm-mhm.

DR. MAXWELL: So do you know if she was trying to progress the rollout? 14:34

A. No, I'm not sure, I don't know. It did -- we did win awards in relation to the HEF and went over to England, you know.

DR. MAXWELL: I know. 14:34

A. So there was great recognition in relation to HEF, and every now and again, even throughout my whole career, HEF has come back up again, somebody somewhere has raised it, or possibly got a call from other Trusts or education providers to have a chat about what HEF was 14:34 and the benefits of it. But I don't believe it was ever rolled out again, and perhaps it was, but I certainly have no knowledge of it.

DR. MAXWELL: Do you use it in your current job?

A. Not at the minute, no. Ehm, we do use other outcome 14:34 tools in my current job, and I suppose one of the reasons why I haven't moved to it is because there is a training issue around it and I don't want to bring it in half-heartedly I suppose in my current role. There is other outcome tools that we're using. I know at the 14:35 strengthening the commitment, which was a regional group of LD nurses, they were really encouraging about HEF and wanted it -- they were really positive on it and would have liked to have seen it brought in across

the region.

DR. MAXWELL: And what outcome tools are you using in your current job? Because your current job is specifically about assessment and treatment.

A. And treatment, yeah. So we use -- a lot of them are actually psychology based outcome tools. So I've worked along with some of the psychologists in our Trust, and they had some that they devised themselves. One of them, for example, is eye map. So some of them are like quality of life outcome tools, and then other ones are about the delivery of care. So outcome tools comes up a lot in your career. I suppose one of my biggest challenges around the outcome tools within learning disability is that we can all use them, but it's how you use them to interpret it, and that's the bit I'd be a wee bit frustrated on, because you can do the tools all of the time, but in terms of interpretation of what these mean for delivery of care is something very different. So at the minute we do have outcome tools, but not the HEF. 14:35 14:35 14:36 14:36

DR. MAXWELL: Thank you.

62 Q. MS. BRIGGS: I'm going to go on to page 10 and on to paragraphs 28 and 29. You describe there how after Donegore you moved to Moylena Ward as a Ward Sister for a couple of months, and this is 2016. 14:36

A. Mhm-mhm.

63 Q. You say at paragraph 29 how Moylena had changed to a ward with three complex needs patients in individual pods, with the patients nursed in isolation. Can you

tell the Inquiry what you thought about the quality of life for those patients living in the pods?

A. Yeah, I suppose I was quite shocked, I suppose shocked to be moved to Moylena and shocked to be working in Moylena. I feel the quality of life for them three individuals would have been a very basic level of care, and possibly one of the reasons for that was because people were perhaps scared of the three patients that happened to be there and maybe didn't understand their needs in terms of level of risk that them three patients perhaps would have presented with. They were in segregated areas, so it was very limited in terms of staff engagement. 14:37 14:37

64 Q. So the patients were living in isolation, and your evidence seems to be that the staff looking after them were scared of them, was that not a very lonely experience for the patients then? 14:38

A. Yes, absolutely it would have been a very lonely experience for the patients. And this possibly improved over time once the staff would have got to know the patients, but sometimes if somebody is nursed within a pod, that physical environment nearly conjures up a fear because your instantly thinking "oh my goodness, these people must be really challenging and that's why they're in such a restrictive environment." Two of the patients I think were non-verbal in terms of their needs, so it would have took a lot of time to get to know them in terms of writing care plans and understanding them, albeit they had also been in the 14:38 14:38

hospital for quite an extensive period of time, it wasn't like they were new to Muckamore.

65 Q. What activities were available for those patients?

A. They possibly would have had day care, out of memory. Possibly not very many sessions, obviously, if they were quite challenging. So they would have left the ward and went to day care buildings, and then obviously I would have encouraged, or would have encouraged named nurses do activities with the patients that were there and to have activity schedules in the ward and encourage therapeutic engagement. One of the first challenges I seen was to get the staff to physically be in the room with the service users. So one of them in particular was in an isolated pod, and the staff would have possibly sat outside that pod so they could observe them at all points, but perhaps might have only been going in to do interventions as opposed to actually sitting in the room with the patient and therapeutically engaging with them. 14:39 14:39 14:39

66 Q. Did it change that the staff were able to go into the room and engage with the patient? 14:40

A. Yeah, I wasn't there a terribly long length of time, so I can't completely recall. I think possibly we did achieve that with some of the nurses, yeah, that they would have got to know them particularly well and tried to encourage all staff to spend time with them, yeah. 14:40

67 Q. I'm going to go to paragraph 30, at the bottom of page 10.

A. Mhm-mhm.

68 Q. You're describing here your move to Erne Ward, and we're in October 2016 now.

A. Mhm-mhm.

69 Q. And you go on in your statement to describe in great detail the challenges of Erne Ward, a resettlement ward with delayed discharge patients, and you were the Ward Sister there, and you worked there for six weeks. 14:40

At paragraph 31 in the middle of page 11, I'm just going to summarise or read out what you say there about Erne Ward. You say that: 14:41

"Initially I was horrified as I had not seen a ward like it before. The physical environment was appalling due to the smell of urine and there were infection control issues. There was dark lighting and it was a depressing ward. Some of the day rooms had curtains, others did not. The bathrooms were disgusting and there was a lack of personal care items in the toilets like towels and bed linen. Overall it was a horrendous physical environment and I found it very distressing that patients were being nursed in this environment. It was very clear to me that there was a lack of external oversight by any senior management and a clear lack of governance afforded to this ward." 14:41 14:41

Could you understand how the ward been allowed to deteriorate to that condition?

A. No. Sorry, I couldn't. I struggled to comprehend how

any ward could be in that condition. I suppose my initial shock was that this ward was on the same site that I had worked in for all these years and didn't know it looked or the care was like that, so...

70 Q. Who was responsible for that, without naming names? 14:42

A. Ehm, I suppose, ehm, I feel the responsibility would lie with lots of people. I don't feel it would be any one person that would be responsible for a ward -- obviously the Ward Sister should provide a great level of leadership, and then obviously H189, and more senior 14:42 management above H189 as well, absolutely.

71 Q. You go on to describe raising your concerns about Erne with your Ward Manager. Did you talk to him about the physical environment?

A. Mhm-mhm. 14:43

72 Q. What was his reaction to that?

A. Yeah. I raised concerns imminently on arrival to the ward. I feel from the outset of me raising concerns, I felt I was perceived to be a difficult person, as if I was possibly overreacting. None of that was said to 14:43 me, but it was body language, and attitude, and demeanour, I felt that I was being difficult.

73 Q. And when you escalated it to your line manager did it go above him? Did he escalate it further?

A. Ehm, I suppose that I took great measures to escalate 14:43 my concerns around that ward and done monitoring reports, and I escalated as much as I could. I would be very confident that above H189 that they were aware of my concerns that I was escalating.

CHAIRPERSON: Were there consultant psychiatrists, or was there a consultant psychiatrist doing ward rounds?

A. There was consultant psychiatrists, yes, but as it was a resettlement ward, they didn't have ward rounds, so they just had resettlement meetings which would have took place just once a month. 14:44

CHAIRPERSON: But on the ward?

A. For the whole ward.

CHAIRPERSON: So at least one of the consultant psychiatrists must have been aware of the state of the ward? 14:44

A. Yeah.

PROFESSOR MURPHY: And there were presumably other resettlement wards in MAH.

A. Mhm-mhm. 14:44

PROFESSOR MURPHY: Were they similar? Did you have reason to visit them occasionally, even if you weren't working there?

A. Well, I had just came from Moylena which was a resettlement ward. 14:44

PROFESSOR MURPHY: Uh-huh.

A. So I suppose it was similar in that it was old and dilapidated and cold, and not therapeutic, but there certainly wouldn't have been issues around infection control. It wouldn't have been to that level, no. 14:45

DR. MAXWELL: Do you attribute that then to the leadership of the previous Ward Manager?

A. Ehm, not in isolation. I don't feel it would have been -- I suppose it just -- I struggled to understand how

one ward could end up in such a state if senior people are in doing walk rounds or supporting that team, that they weren't aware of it.

DR. MAXWELL: And that's what I'm wondering. If, you know, there were a series of wards of the same age in deteriorating physical condition, but this one was significantly more hazardous to patients than the others, is your evidence, I'm wondering why you think it would have been singled out not to be maintained by senior managers? 14:45

A. Yeah. I don't know.

DR. MAXWELL: Or whether it was due to the local Ward Manager not raising issues, not actioning the issues?

A. Yeah. I suppose I can't answer that. Perhaps it was the fact that I was the one raising the concerns and perhaps other people didn't. 14:46

DR. MAXWELL: Okay.

74 Q. MS. BRIGGS: At paragraph 32 you say that you couldn't be assured over staff practices due to the physical layout of Erne Ward. The office you describe as being out of sight from the day care spaces. And you say later in that paragraph that you didn't see any physical abuse, but you say: 14:46

"I was still concerned over the patient care being provided." 14:46

What were your specific concerns about the patient care?

A. Ehm, I suppose they were quite extensive, my concerns. I suppose I feel they were indicators of institutional abuse. I feel that -- I described it back then as willful neglect of patient care. So whilst I didn't see any staff member harm any patients, ehm, I felt the patients were neglected. It was a very basic level of care delivery. Ehm, I suppose the smell of urine in the ward itself physically would have repulsed you. There was lots of environmental repairs that I later got done, and they were extensive, and they were due to the poor cleanliness of the ward and the neglect that had happened over a prolonged period of time. Ehm, patients I suppose not engaging in any form of therapeutic activity and lying in their beds for prolonged periods. Ehm, I suppose there was a multitude of concerns. I don't know if you want me to go through them all, they're in my statement, do you know. 14:47 14:47 14:47

75 Q. We'll go to some of them in a moment. You spoke to H189 about this, and had no-one else spotted what you had seen? 14:48

A. I honestly don't know. Yeah, I raised my concerns. Well I suppose actually there was an RQIA inspection prior to me coming into that ward, I suppose I should highlight, which did uncover a lot of the concerns about Erne. So they, I think out of memory they made something like 35 recommendations for one ward, which back then, and actually now, that's a lot of recommendations for any service. So I had read the 14:48

report and I understood the enormity of where I was going to in terms of my role. But I feel on arrival into the ward, like I feel RQIA only touched the surface of the concerns.

76 Q. And you had obviously read the RQIA report in preparation for going in. 14:48

A. Mhm-mhm.

77 Q. When you got there, were the other staff on the ward, were they aware of what was in that RQIA report?

A. Mhm-mhm. 14:49

78 Q. Were they talking about it?

A. No. I suppose it's very difficult, difficult time. Yeah, the staff, I don't feel -- there wasn't any chat about RQIA, or reports, or making it better. I suppose they were probably -- I'm trying to look back positively. You know I had just replaced a longstanding Ward Sister, do you know, so there wasn't, I probably wasn't welcomed into the ward, you know, wouldn't have been embraced, if you worked with somebody for so long and then I'm the one replacing them. So they were probably more upset about that at that point in time, do you know, in terms of the change in leadership. 14:49 14:49

79 Q. So you didn't --

CHAIRPERSON: I'm so sorry to interrupt. 14:49

MS. BRIGGS: Sorry, Chair.

CHAIRMAN: But how many ward staff were there on that ward across the shifts?

A. Quite a lot. It was probably one of the largest teams

I had ever managed. Out of memory I think there was about 40 staff on the rota, which was quite a lot, and per shift we possibly worked with about maybe 10 or 12 staff, it was quite a high number of staff per shift, which was really due to the physical environment, because the patients were all in like wee sitting rooms, so it was very hard to observe the level of care, because every day space was through a door as such.

CHAIRPERSON: And what proportion of those would have been healthcare assistants and what proportion would have been nurses? 14:50

A. Yeah. The skill mix wouldn't have been very good in that ward. There definitely would have been a high level of healthcare assistants. 14:50

CHAIRPERSON: Thank you.

80 Q. MS. BRIGGS: Did you hear any of those 40 staff discussing the RQIA report at any time?

A. No.

81 Q. When you think about that group of staff, what were they like when you arrived? I mean you replaced a longstanding Ward Sister. Were the staff that were there, were they a cohesive team that already existed and wanted to do things their way, or were they more a disparate group of poor staff? How would you describe how they were? 14:50 14:51

A. Yep, it was a very difficult time for me. They weren't very compassionate. They definitely didn't, I suppose they didn't want me there. I suppose I'm struggling --

I suppose I tried to think that that was because the previous Ward Sister had retired, do you know, so they possibly just missed her. Ehm, they had been there a long time, and perhaps maybe they were upset by the RQIA inspection and maybe, you know, you always try to put myself in other people's shoes, maybe they didn't like the criticism that they had received, you know, from the RQIA inspection, you know, and perhaps they thought the care was good, and all them things. So, no, they certainly didn't embrace me as a new person coming in to improve things. 14:51 14:51

82 Q. And would you say they weren't particularly responsive then to your influence?

A. No.

83 Q. At paragraph 33, we're at the top of page 12, you say that your concerns included - and you list them - they included lack of governance, lack of infection control, no patient structure or routine, care plans were out of date, and there was non-adherence to policies and procedures. You give an example later in your statement at paragraph 40 of the finance policy not being complied with. 14:52 14:52

A. Mhm-mhm.

84 Q. What other examples did you see of a failure to follow policies and procedures? 14:52

A. Ehm, I suppose the finance policy. The controlled drug policy wasn't being adhered to. Controlled drugs, there's a very strict policy in place for all controlled drugs within any ward, where you're meant to

balance the stock every shift in the morning when you come in as a nurse in charge and hand over medication from shift to shift, ehm, and any administration of controlled drugs is meant to be with two nurses to sign administration off and verify that the dose is correct. Ehm, them records wouldn't have been maintained within that ward. Ehm, so you could never be assured of the stock, because you didn't know how many were supposed to be there initially because the drugs weren't being counted appropriately. 14:53

85 Q. Yes, you describe that at paragraphs 36 and 37 of your statement, and you say that the stock on the controlled drugs trolley just never seemed to balance.

A. Mhm-mhm.

86 Q. Was that as a result of medication not being given, or too much medication being given, or was it even possible to tell? 14:53

A. I couldn't answer that. You couldn't tell, I suppose. I mean lots of -- you would have drug errors, you know, they're not uncommon. Even with controlled drugs, you know, nurses can make mistakes. You can just drop a tablet and have to dispose of it, and all of that is okay as long as it is recorded and you adhere to policies and you complete your incident forms, then you have evidence and rationale as to why things happen. So I'm not sure why. 14:53 14:54

DR. MAXWELL: Can I just ask, because normally, because this comes under the medicine sacks, so that would technically be reportable to the police.

A. Mhm-mhm.
DR. MAXWELL: Were pharmacy not doing drugs reconciliation on the wards?
A. Yeah, the controlled drugs would have, out of memory, always would have been well regulated by the pharmacists. The pharmacists didn't work on the Muckamore Abbey site, so that would have been a -- 14:54
DR. MAXWELL: But did they not visit?
A. They would have visited, yeah, they would have come down. 14:54
DR. MAXWELL: And do reconciliations.
A. Yea.
DR. MAXWELL: So are you talking about one incident when you found it wasn't reconciled?
A. Well I was only there for six weeks, but it would definitely have been more than one. 14:54
DR. MAXWELL: And you reported it to pharmacy as soon as you found it, I presume?
A. I would have -- I can't remember what the policy was at that time, but you would have done an incident form in terms of reporting it through. Ehm, you don't report through straightaway to pharmacy when controlled -- with the stocks not correct. 14:55
DR. MAXWELL: Even with controlled drugs? That wouldn't be my experience. 14:55
A. No?
DR. MAXWELL: My experience would be you would have to tell pharmacy straight away.
A. I can't recall.

DR. MAXWELL: Okay.

87 Q. MS. BRIGGS: You do say, on the topic of the medication stock balance, you say at the end of paragraph 37 that you reported it on to your line manager and that the action was taken, but that was simply to remind the team of policy and guidelines, was that all that was done. 14:55

A. Mhm-mhm. Yeah.

88 Q. And you say in that paragraph as well that pharmacists would have made unannounced visits? 14:55

A. Mhm-mhm.

89 Q. Should that have picked up on the issue, do you think?

A. Yeah.

90 Q. Can you say why it wasn't?

A. I suppose I can only speak of the time that I was there. Perhaps the pharmacists did pick up on it. I don't know, I certainly wouldn't have been informed. 14:56

91 Q. I'm just going to jump back a little bit to paragraph 34. You're describing in that paragraph how you raised concerns to your line manager, and you describe the use of the monitoring forms, which are forms for Band 8As to complete to monitor their own wards. You say you used this form as a way to escalate your serious concerns to your line manager. Now this is 2016 that you worked on Erne Ward, can you remember when those forms were introduced? 14:56

A. I don't recall.

92 Q. Right.

A. I know they weren't for Ward Sisters to complete, they

were for senior management to use on their wards.

93 Q. Do you think at this time they felt relatively new or do you think they had been around for a while at that point?

A. No, they definitely would have been new. 14:57

94 Q. Okay. You say at that paragraph the support you received or didn't receive in response to the forms. You say halfway through the paragraph 34:

"I did not feel supported during this time. The responses I received back were unsatisfactory, unhelpful and intimidating." 14:57

What level of management was that coming back from, that unhelpful response? 14:57

A. Senior management, your line manager.

95 Q. So your line manager?

A. Mhm-mhm.

96 Q. Okay.

CHAIRPERSON: And what do you mean by "intimidating"? 14:57

A. Ehm, well I suppose that I recall sending one the monitoring forms and my response back would have been "And what are you going do about it?", which I felt was unhelpful when I was the one raising the concerns. So it felt like "Well, you've found these problems, so you need to fix them. You're the Ward Sister now so what are you going to do about it?" 14:58

CHAIRPERSON: So you were escalating concerns?

A. Yeah.

CHAIRPERSON: And it was being pushed back to you, as it were, to say "You get on with it, it's your problem."

A. Yeah.

PROFESSOR MURPHY: Do you think that what happened was that your line manager wanted Erne sorted out, saw that you had done a really good job in Donegore and thought "Oh, she'll sort it out", and put you in Erne? 14:58

A. That's exactly what happened, yeah.

97 Q. MS. BRIGGS: Would you say it was possible or not possible to make those changes without the support of your senior management? 14:58

A. Ehm, well I later had to go back to Erne and did make them changes, and I believe I was only able to do that with not just a -- there was a change in senior management, but more importantly it was the entire staff team changed, so it was a more positive culture. 14:58

98 Q. We'll come on to that return to Erne Ward in a moment. You've just picked up there on the more positive culture, and that's something I was going to ask you about next, because you describe in your statement that the ward culture on Erne was not positive, and that's at the end of paragraph 35 on page, the top of page 13. Some witnesses have told the Inquiry in their statements that they don't know what the expression "a ward culture" means. What do you mean by it? 14:59 14:59

A. Culture to me means, ehm, that it's a positive environment, that there's leaderships at all levels of staff within that team. Ehm, that staff are actively

engaged in care delivery. Ehm, that patients can be directly involved in their care. Ehm, that staff, I suppose, know how to raise concerns, and that they're supported to raise concerns. Ehm, and that there's a positive ethos in the ward. 15:00

99 Q. And who shapes or who develops that culture?

A. Ehm, I suppose it comes from leadership. And I was always very proud of being a Ward Sister, you know, and I always thought that was very much part of the Ward Sister's role. Ehm, but I feel quite strongly that 15:00 leadership is at all levels, it's not just about one person, and it is just one Ward Sister being the best that she can be, and I suppose that's a difference. Some wards management are managers, and other people are leaders. Ehm, so I feel the culture in any ward is 15:00 shaped I suppose by the person at the top, but you can't do that on your own.

100 Q. If we can go down to paragraph 39 on page 14, you're describing there that in a ward environment you have to be able to rely on care plans, and you describe your 15:01 concerns around patient's care plans on Erne Ward not being up-to-date?

A. Mhm-mhm.

101 Q. And you describe towards the end of that paragraph how there were patients in the ward who were meant to be 15:01 ready to live in the community, but this would not have been possible given the lack of up-to-date care plan to support them. Are you saying that discharges were delayed because of the lack of an up-to-date care plan?

A. No, I don't believe that's why they would have been delayed, no. I believe the discharges would have been delayed because of lack of appropriate placement in the community, but I suppose I felt how could -- even if they had have had a community place identified for these patients, how could we have safely and effectively discharged them when their care needs weren't up-to-date? So how would you share that information safely with a community team or an organisation that was going to take these patients into their care, if they weren't receiving up-to-date information about them? 15:02 15:02

102 Q. So what you're saying is that for those patients that there wasn't an option for them at the moment in the community, but if there had have been you would have had real concerns about their move to the community because of the state of their care plans? 15:02

A. Yeah. That's right.

CHAIRPERSON: And can I just ask, how up-to-date does a care plan need to be? Are we talking about a monthly review or six monthly? I don't have a sense of it? 15:02

A. Yeah, and sometimes it's hard to be that prescriptive in nursing in terms of writing care plans. But, yeah, absolutely, you would like -- I mean I suppose there's a named nurse, and I'm sure you've heard of that structure, within ward teams, and each patient has their own named nurse. So I always would have advised and encouraged nurses to assess, do a review of the patient's needs monthly, or perhaps three monthly, or 15:03

sooner if their needs change or if there's an increase in risk, or their behaviours change, then they would reassess their care plan.

DR. MAXWELL: But there's often a policy about how often it should be review, so you review it even if you don't update it. Was there a policy about how often the named nurse should review the plan? 15:03

A. There possibly was, but I --

DR. MAXWELL: Well, what was your expectation as a Ward Sister? What would you have considered to be reasonable for a review, even if no change was required? 15:03

A. That's what I'm referring to. Even, you know, as they were -- named nurses assess their patients monthly.

DR. MAXWELL: Monthly? 15:03

A. Yeah. Even if there was no change, they would write "no change".

DR. MAXWELL: So are you saying that it was your perception that they weren't reviewing the care plans monthly? 15:04

A. Yeah.

103 Q. MS. BRIGGS: You describe later on in your statement, H112, paragraph 43 on page 16, how you resigned from your role in Erne Ward after six weeks, and you talk about your feelings of guilt about that. But what I'd like to is move on to your next ward now. 15:04

A. Okay.

104 Q. We're coming somewhat towards the end of your time in Muckamore. Paragraph 44, page 16, you moved to Six

Mile?

A. Mhm-mhm.

CHAIRPERSON: Could I just ask, as we're moving on, how much longer do you think you've got to go? The witness has been going about an hour and ten minutes. 15:04

MS. BRIGGS: I think about half an hour to 45 minutes left, Chair.

CHAIRPERSON: I think we ought to take a break.

MS. BRIGGS: Yes, I think so.

CHAIRPERSON: But just going back to care plans. Can you now remember, because obviously you were concerned that care plans weren't being kept up-to-date, what the sort of worst period was that you saw where a patient's care plan hadn't been updated? Do you have any recollection? 15:04 15:05

A. Possibly about a year out of date.

CHAIRPERSON: A year?

A. It was definitely extensive.

DR. MAXWELL: Is that a year when it hadn't been reviewed or a year when it hadn't been updated, because the two might be different? 15:05

A. Ehm, both. No nurse had looked at them within a year, so they hadn't been -- I suppose, ehm, I couldn't evidence any form of a review, so even if the changes had - if the patient's assessed need didn't change, you would have been able to find the date that they had reviewed that, but there was -- 15:05

DR. MAXWELL: But you couldn't find a date of review?

A. No.

CHAIRPERSON: All right. We're going to take a short break, just because giving evidence is actually very hard work, and we'll take 15 minutes.

A. Okay.

CHAIRPERSON: But after that you'll have a much shorter session than you've had so far. 15:05

A. Okay.

CHAIRPERSON: All right. Thank you very much indeed.

A. Thank you.

CHAIRPERSON: You can obviously speak to anybody, but don't speak about your evidence. 15:06

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS:

15:27

CHAIRPERSON: Thank you.

105 Q. MS. BRIGGS: H112, I'd like to re-start by asking you a couple more questions about Erne Ward the first time you were there, okay?

A. Okay. 15:28

106 Q. And that was the six week period that you worked there. You've given evidence to the Inquiry in your statement and in your oral evidence about how you raised your concerns over the serious issues that you saw there.

A. Mhm-mhm. 15:28

107 Q. The likes of the medication concerns that you had, the concerns over care plans, the concerns over the environment and so on and so forth. When you came into Erne Ward as a Ward Sister, what were you told about

how to report concerns in those areas?

A. Ehm, I don't recall being told how to report concerns.

108 Q. So you were using your initiative, would you say then, when you reported things on to your line manager?

A. Yeah. Yeah. 15:29

CHAIRPERSON: Wouldn't that have been part of your basic training, how to report concerns?

A. Ehm, well, yes, I suppose how to make a complaint, ehm, would have been mandatory training. Ehm, there was possibly a whistle-blowing policy, ehm, I remember 15:29 circulating at a period of time. But I don't remember specific training on how to raise concerns other than, I suppose, your adult safeguarding training, which would be, I suppose, different to raising concerns in terms of whistle-blowing. 15:29

DR. MAXWELL: And it would be part of your code of conduct.

A. Yeah.

DR. MAXWELL: So you wouldn't expect to be trained. By being a registered professional you know you have to 15:29 adhere to your code of conduct?

A. Yeah.

109 Q. MS. BRIGGS: You've given evidence about your concerns over the ward environment, and the smell of urine and so on and so forth. What was it about specific staff 15:30 to patient care that concerned you?

A. Ehm, I suppose there was an apathy about the ward. Ehm, there was a lack of therapeutic engagement. Ehm, so perhaps staff would have been looking after patients

but wouldn't have been actively engaged in any form of activities. Ehm, the fact that perhaps if you had have came on shift at lunchtime, ehm, some patients were still in their bed. Ehm, so that would have concerned me, that patients weren't woke at appropriate time and personal care attended to, or encouraged to attend day services. Ehm, so I suppose it was just the culture within the ward and the negative attitudes.

110 Q. And the sum of all this is that when you spoke to your line manager about it, really nothing was done? 15:31

A. Mhm-mhm.

111 Q. Is there another avenue you think you could have took, looking back, or might have been able to take, in terms of escalating your concerns?

A. Mm-hmm, I don't know what you mean? Like another person that I could have sought out, I suppose? Ehm, yeah. Well I suppose I did seek advice from the RCN, which was the Royal College of Nursing at the time, in terms of support for me. Ehm... 15:31

CHAIRPERSON: You say you did seek advice? 15:31

A. Yeah.

CHAIRPERSON: Did you get it?

A. Not particularly, no. I don't feel I was appropriately supported by RCN as a professional body, no. Ehm, no.

DR. MAXWELL: What was their response? 15:32

A. Ehm, well I suppose I'm able to talk a lot, as you can tell. I was able to say the things that I felt I might do. So like the monitoring forms. So they agreed, yeah, that would be a good idea, but I was strongly

encouraged to become a staff side rep, a trade union member, so that that would encourage me for the future so that this wouldn't happen to me again.

DR. MAXWELL: So not professional issues?

A. But not professional. 15:32

DR. MAXWELL: And you've talked earlier about working with Molly Kane, who is the LD nursing lead, or was at the HA when you introduced the outcome audit.

A. Yeah.

DR. MAXWELL: Did you think about seeking professional advice from her? 15:32

A. No.

CHAIRPERSON: No, we're okay with that name.

INQUIRY SECRETARY: No, Chair, we need to stop, there's a technical issue with the stream, so we just need to -- 15:32

CHAIRPERSON: Oh, is there? I'm sorry. I thought it was the name. Okay, we'll just stop.

INQUIRY SECRETARY: If we just pause for a minute.

CHAIRPERSON: Sorry. Sorry. Have we lost the feed? 15:33

INQUIRY SECRETARY: Yeah. The feed has been cut to Hearing Room B.

CHAIRPERSON: Okay. Can we just pause for a moment until it is sorted out. Is there anybody in Hearing Room B? 15:33

INQUIRY SECRETARY: Yes.

CHAIRPERSON: Okay. Is this also affecting the video feed?

INQUIRY SECRETARY: Yes.

CHAIRPERSON: I don't want to rise, because if I rise it'll be another 10 minutes before this lot come back into the room! Are we okay? Apparently we're good to go. So the last question was from Dr. Maxwell:

"You talked earlier about working with Molly Kane, who is the LD nursing lead. Did you think about seeking professional advice from her?"

And you said "no". That's the last bit we've got. 15:36

DR. MAXWELL: So in your experience was there no forum where LD nurses could seek professional support and discuss issues?

A. Within the Belfast Trust?

DR. MAXWELL: Within Northern Ireland. Because you've said that the RCN weren't particularly helpful. 15:36

A. Mhm-mhm.

DR. MAXWELL: Sometimes there are forums and special interest groups with certain specialities.

A. Mhm-mhm. 15:36

112 Q. DR. MAXWELL: Are you saying there was nowhere really where you could have gone outside line management to have a professional discussion?

A. Well there was -- I can't remember the time of year. I mean there was the RCN Learning Disability Forum, which I also was a part of, so I would have had lots of colleagues regionally that would have formed part of that forum. Ehm, I suppose I was probably particularly anxious because it's very hard to raise concerns about 15:37

your own service in the ward that you're working in, so I did feel very compromised and I suppose I initially sought the advice from the RCN as a trade union, where as a nurse you're always advised to go and get professional support and advice. Ehm, so, no, I suppose they didn't speak in a public forum because it felt inappropriate.

DR. MAXWELL: Okay.

113 Q. MS. BRIGGS: H112, you moved to Six Mile after your six weeks in Erne Ward, and you were there November 2016 until January 2017 as a Deputy Ward Sister and then a Ward Sister. 15:37

A. Mhm-mhm.

114 Q. How did Six Mile compare to Erne?

A. Eh, yeah, well Six Mile was one of the core hospital wards, ehm, so obviously the physical environment was bright, vibrant, ehm, not overpopulated, it was split into two wards, so an assessment side and a treatment side. Ehm, a higher skill mix of staff as well. So, ehm, I suppose more nursing registrants working within the ward. Ehm, and it was a forensic ward. Ehm, so there was lots of service users and patients there that would have been -- came into contact with the Department of Justice, ehm, and there was a large multidisciplinary team within that ward who had a visible presence. 15:38 15:38 15:38

115 Q. So the patient care was better?

A. Yeah.

116 Q. Paragraph 45 on page 17, you tell the Inquiry there

about the difficulties with short staffing while you were on Six Mile and having staff allocated to other wards to assist short-staffed wards, and you describe how difficult decisions had to be made around patients with planned outings if there weren't enough staff on.

A. Mhm-mhm.

117 Q. Was that level of short-staffing in late 2016/early 2017, was that worse than at other times in the hospital?

A. Ehm, I suppose that part of my statement, that's not unique to Six Mile, that staffing, I suppose, to them difficult decisions would have happened across the site in all wards about maybe having to cancel planned outings that patients had if you didn't have enough staff on shift. Ehm, I suppose staffing changed obviously in 2017, ehm, when the adult safeguarding and the investigation started. So definitely the staffing would have been much worse then in terms of substantive staff. Ehm, but for a prolonged period of time in Muckamore there was also, ehm, staff that weren't permanent, so they would have had temporary contracts. Ehm, I myself was on a temporary contract I think for approximately seven years as a Ward Sister. Ehm, so...

DR. MAXWELL: But I think that had been resolved by January 2017, hadn't it? We've heard evidence that actually although that had been a policy, I think some time around 2015/16, they started issuing permanent contracts.

A. Okay. Yeah. So I only received my permanent contract

when I moved back to Erne, so that would have been in 2017, yeah.

DR. MAXWELL: Yeah. So in January 2017, before the allegations and the large safeguarding, when you were on Six Mile and having to send staff to other short-staffed wards, was that something you had had to do when you were in Donegore, for example? Had you had to send your own staff to cover? 15:41

A. Yeah. That would have happened in all wards.

DR. MAXWELL: So this was common practice across your whole time at Muckamore? 15:41

A. Yeah.

118 Q. MS. BRIGGS: Did consultants have any part to play in helping with short-staffing issues?

A. No. 15:41

119 Q. Were Ward Sisters or Ward Managers encouraged in any way to speak to consultants if they needed support with short-staffing?

A. Ehm, I suppose there possibly might have been advice if wards were short-staffed. I suppose one of the main reasons for requiring a high level of skill mix is if patients are nourished on levels of observations. So if your patient acuity is high, that requires you to have more staff. So perhaps during times of particularly difficult staffing, people might -- senior management might have asked you to go and speak to your consultant to see if a particular service user still requires that levels of observation or could they be reduced temporarily to support the staffing crisis that 15:41 15:42

you would be in? But other than that, consultants wouldn't be involved in nursing staffing, no.

120 Q. If you go on to page 18, paragraph 48. You're describing here waiting for a permanent Band 7 post and how one was advertised in Erne, and you got that post and you had to go there again. 15:42

A. Mhm-mhm.

121 Q. This is February 2017, so it's not very long at all after you last left Erne. You go on to say at paragraph 49 how senior management had changed, and you talked about this earlier in your evidence. You say that you discussed with senior management the need to move the current staff team out of Erne to enable real change to happen. 15:42

A. Mhm-mhm. 15:43

122 Q. And then about 90% of the staff on Erne were actually moved to other wards?

A. Mhm-mhm.

123 Q. Was that because of your discussion with the new senior management? 15:43

A. Yeah. That's right.

124 Q. And when you say "new senior management", do you mean your line manager had changed?

A. Yeah, they weren't new people. I suppose the line manager had changed over the wards, which would have happened routinely in Muckamore. 15:43

125 Q. So your line manager had changed. Was that really the only shift that you saw when you came back into Erne, until they then moved the other staff out?

A. Yeah, that's right.

126 Q. Okay. So effectively to change the culture on that ward you felt that you needed to remove the whole team of staff really. Is that fair to say?

A. That's right, yeah. 15:44

127 Q. And in terms of the staff from Erne who were moved, can you recall where exactly in the hospital they were moved to?

A. No. I suppose they just would have been dispersed throughout the hospital, which wouldn't have been 15:44 uncommon for Muckamore, you know, that staff would have been moved wards.

128 Q. Did any of them go to the likes of PICU, do you know?

A. Not that -- I can't recall.

129 Q. Do you know whether any information about their 15:44 practice was shared with the wards that they were going to?

A. I couldn't answer that. I suppose I don't know. I say that in my statement, I gave the information that I felt was appropriate to share, me of my role, but I 15:44 have no understanding of any action that was taken following my resignation.

PROFESSOR MURPHY: So your information you gave to your line manager, did you?

A. Mhm-mhm. 15:45

PROFESSOR MURPHY: And the line manager handled the re-allocation, is that how it happened?

A. Yes.

DR. MAXWELL: So are you saying that whilst you're

working on Six Mile...

A. Mhm-mhm.

DR. MAXWELL: These staff somewhere been dispersed. So this decision to change 90% of the staff had happened while you weren't working on Erne Ward? 15:45

A. No. So I was in Six Mile and then applied for the permanent post, because I had been waiting so long on one.

DR. MAXWELL: Yeah.

A. Ehm, was told that I had to go back, and then when I went back I spoke to the line manager and said that the only way this is possible is we change and move the staff team, and I identified key people that I would have had experience in working with over the years, really positive people, so I could seek them out to help me improve this ward. 15:45

DR. MAXWELL: So you were identifying with your manager, when you went back to Erne, there were people whose practice you thought was poor.

A. Mhm-mhm. 15:46

DR. MAXWELL: And that you thought the only way to change Erne Ward was for those people not to work on Erne?

A. Mhm-mhm.

DR. MAXWELL: But that means people with poor practice were going to other wards. Did you, with your manager, actually identify what the limitations to their practice were so that the Ward Sisters on the new wards would know that these people had some capacity issues 15:46

or performance issues to be dealt with?

A. Well I believe I raised significant concerns about that staff team, so that line manager would have had that information.

DR. MAXWELL: And did you document for every individual member of staff? 15:46

A. No, I documented it in the monitoring report. So I suppose I wouldn't have documented it individually.

DR. MAXWELL: And did any of the Ward Sisters receiving these staff ever contact you to say -- 15:46

A. No.

DR. MAXWELL: -- what were the concerns about this?

A. No.

130 Q. MS. BRIGGS: H112, you say later in paragraph 49, and this is towards the end of page 18, you say that on 15:47 your return to Erne:

"I tried to get management to change their perception of the function of the ward so that it was no longer deemed to be a resettlement ward. This was influencing 15:47 the level of resourcing we received and the standard of care being provided to the patients."

Had Erne really just become a bit of a waste ground for patients that were waiting discharge. 15:47

A. I believe so, yeah. It felt like the forgotten ward.

131 Q. How could that have been avoided, looking back?

A. By improved leadership, by governance arrangements. Ehm, that having a senior, or presence of senior

management, senior Belfast Trust staff beyond Muckamore. Ehm, I suppose it's important also to highlight, I suppose, it's not just about nurses, albeit I feel I've talked a lot about nurses today, and even in terms of staffing, there was other allied health professionals that didn't enter into that ward. I suppose I feel in any environment that can lend itself to closed culture indicators is the lack of visible presence of anybody beyond the nursing team within the ward. 15:48

132 Q. And the likes of allied health professionals, they just weren't coming into Erne?

A. So my recall of that was to do with funding. Ehm, so if you were a resettlement patient, you were only allocated -- you didn't require referral to behaviour services because you weren't on active treatment, so you didn't need an occupational therapists, you didn't need all these other allied health professionals. Ehm, so I suppose that, when I talk about I felt it was really important to get these patients reassessed, that was a difficult conversation because I couldn't do that on my own, and that was about having consultant psychiatry support with that, and senior management as well, so to take some of the patients, not them all, out of delayed discharge, because I didn't believe they were ready for the community, albeit they were classified as that. So that would have affected your reporting of figures to the Department of Health in terms of so many people are delayed in their discharge

and are waiting on community places, I didn't feel that all of them were ready.

133 Q. Your attempts to change the look of Erne Ward from a resettlement ward to something else, and your attempts to look at the status of patients as delayed discharge, or whether they were ready for discharge, did your efforts to try and reshape or reframe what Erne hospital was, did that work? You were there for 15 months the second time? 15:49

A. Yeah. No, it did work, yeah. Ehm, we were able to -- even down to the name of the ward, you know even the name "resettlement", I didn't like the name of the ward in terms of the image that that conjured up. Ehm, "continuing care" I think possibly was the name that I wanted to call it, so in terms of classification we were a continuing care ward, we weren't a resettlement ward. Ehm, so once I was able to bring about that change, out of memory I think there was two patients that we reclassified and put them back into active treatment, ehm, which enabled me to refer them then to multidisciplinary teams and to get professionals involved in their care, and we absolutely improved their quality of life. Ehm, I was then also able to get more resources for the ward and get CCTV installed into Erne as well, because it was no longer a ward, ehm, that was closing. So I suppose that was probably the thought behind it, "This ward is closing anyway, what's the point in spending any money on it? The patients are going into the community and we're going 15:49 15:50 15:50 15:50

to close it down."

134 Q. So would your evidence to the Inquiry be that through good leadership, you and your line manager were able to make the necessary changes to Erne Ward?

A. Yeah, and the team, the team within it. 15:51

135 Q. Paragraph 53 on page 20, you're saying there how you felt that the culture on the wards was predominantly positive except for Erne Ward. But you say that you felt that the culture of the wards changed in and around 2017 due to the Adult Safeguarding Investigation? 15:51

A. Mhm-mhm.

136 Q. And at the end of that paragraph you say:

"From 2017 onwards I feel there were several changes in senior management who appeared under significant pressure, understandably, but appeared to be aggressive in their management rather than leading the service to bring about positive change." 15:51

15:52

What do you mean by the phrase "aggressive in their management"?

A. Ehm, I suppose there was a lot of changes in the Belfast Trust, ehm, repeated changes in management team. I feel you could have came in one day and there was entire new senior management team, and then they maybe stayed for a while and then they also moved on. Ehm, and some of them at that point in time they would have been aggressive in meetings, that you would have 15:52

been in meetings with other Ward Sisters, ehm, and they would have perhaps banged the table when they were talking and were telling you and instructing you to do things in terms of staffing, any difficult conversations when you were trying to have operational meetings.

DR. MAXWELL: Were these people who were being brought in to Muckamore as a result of this?

A. Mhm-mhm.

DR. MAXWELL: It wasn't the existing senior management? 15:52

A. Yeah, that's right. They were brought in to improve it.

137 Q. MS. BRIGGS: The next part of your statement, I'm going on, it addresses a number of themes or topics, and I'm going to touch on a few of those, not all of them. 15:53 Okay? You describe in your statement the adult safeguarding process and how it worked and what it was, and for reference that's paragraph 56, page 21.

A. Mhm-mhm.

138 Q. We don't necessarily need to go to that paragraph 15:53 specifically, but what was your view of the adult safeguarding process? Did it make sense to you how it was done?

A. Yeah, I know, and I suppose it feels very ironic answering that question in a positive given why we're 15:53 here, which is quite upsetting. Ehm, but I do believe at that point in time that it was a really positive appointment in appointing the adult safeguarding. There was a DAPO appointed solely to look at adult

safeguarding on the whole site. Prior to that, the adult safeguarding would have been managed by social workers. So there wasn't one person with a specific role directly relating to adult safeguarding. So any ward that I was in I had a very positive experience of the adult safeguarding officer who would have came to the ward when there was an adult safeguarding referral being made, ehm, who would have met with the service users, who would have met with the staff, who would have tried to support decision making, who would have done case discussions. Ehm, I found, in the wards that I worked in, it was always very positive. 15:54 15:54

139 Q. And what would your involvement have been in that process?

A. Ehm, well I always tried to -- I would have supported the DAPO when he first took up post, and support his knowledge, because he came from a mental health background, ehm, and I would have supported him, I suppose from a learning disability perspective, and tried to give him the perspective of how I always wanted to link adult safeguarding to care planning, I didn't want the adult safeguarding to sit outside of the care plan, so I would have, I suppose articulated it, and showed him how we would have incorporated that into our care plan, anybody, any patients that would have had a protection plan in place, that we would have recorded that within the care plan. Ehm, I would have set up new initiatives, like adult safeguarding boards, so that when you came into the ward, like we were very 15:54 15:55 15:55

acutely aware of the amount of protection plans we had at any given time. So that it absolutely was everyone's responsibility and everybody's business, which is what adult safeguarding is, and that's what it says in the policy, but it was trying to really reinforce that.

140 Q. You describe, H112, in your statement, another topic, and that's the difference between resettlement wards and core hospital wards. Sorry, Dr. Maxwell.

DR. MAXWELL: Sorry, just before we move on. We've heard from other witnesses that after the allegations from the CCTV came to us, the team who were looking at the CCTV changed the threshold. So you talk about the fact that the policy actually says the Band 7s initially look at something and screen it in or out and refer to the social worker.

A. Yes. Mhm-mhm.

DR. MAXWELL: And there seemed to be some confusion about what staff were supposed do, whether all instances were supposed to go to a DAPO, whether you were still as a Band 7 able to do the screening.

A. Mhm-mhm.

DR. MAXWELL: Were you always clear what the procedure was?

A. Yeah. I mean my understanding at the time, the regional policy was that Band 7s would screen out or screen in, and I was always very clear.

DR. MAXWELL: And the policy stayed like that all the way through?

A. Yeah.

DR. MAXWELL: Okay. Thank you.

141 Q. MS. BRIGGS: One of the things we touched on today, and it's throughout your statement, particularly at paragraph 54, you describe the differences between resettlement wards and the core hospital wards, and you've said it today as well that the core hospital or newer wards they were better resourced, better environments, newer environments. The Inquiry understands that many allegations of abuse were on wards in the new hospital, in the core hospital. 15:57 15:57

A. Mhm-mhm.

142 Q. Why do you think that might have been?

A. I don't know. Ehm, I don't know.

143 Q. If we can go to paragraph 57 on page 22. You're reflecting there on Ennis Ward. You never worked on Ennis Ward, but you're reflecting about the learning that was obtained from the Ennis Investigation in 2012, and you're reflecting to say there that you feel that the learning from Ennis wasn't shared sufficiently with the rest of the hospital. What learning do you think ought to have been taken from Ennis and how do you think it ought to have been shared with the rest of the hospital? 15:57 15:58

A. Ehm, well I mean I suppose I worked there for a significant period of my career and I didn't know what the concerns were in Ennis Ward. Ehm, I understood it later when I went to work for RQIA, but during my period of time in Ennis I didn't know the detail of the 15:58

allegations. Ehm, I repeatedly would have asked for the report in relation to Ennis, ehm, for I absolutely wanted to learn from it and make sure that that didn't happen in my ward or any ward that I worked in. Ehm, but the report was never shared. I didn't know the 15:58
level of detail. Ehm, there was a monitoring role for Ward Sisters in Ennis, ehm, where we -- where people were asked to go over and work and monitor the care, ehm, which I struggled, I didn't want to fulfil that role, I suppose. I was quite inexperienced as a Ward 15:59
Sister, and the Ward Sister there was a lot more experienced than me, and I didn't feel I was possibly the most appropriate person. I also didn't know what I was monitoring, I didn't know the level of concern within the ward. Ehm, I suppose Ennis does upset me 15:59
that that happened on that site and I didn't know about it, I didn't know the learning, and I often reflect that, you know, Ennis happened in 2012, I raised concerns in 2016, do you know, and then we have 2017, I suppose, and that makes me concerned that, you know, 15:59
how do you know, or how do I know that maybe some wee nurse somewhere sitting in PICU or, you know, perhaps was, you know, was scared to report things or raise concerns, because I raised concerns and I had to resign from my role, you know, and I was a senior Ward Sister 16:00
in that hospital, I'd like to think possibly some of the nurses would have looked up to you, do you know? Ehm, so I feel that was absolutely categorically huge missed opportunities for the Belfast Trust, not just

Muckamore.

CHAIRPERSON: So the learnings from the Ennis Report, as it were, weren't distributed?

A. No.

CHAIRPERSON: There was no engagement session that you were aware of with staff following the Ennis Investigation? 16:00

A. No.

CHAIRPERSON: And when you say you were asked to go and monitor wards or monitor performance, was that following people being suspended? 16:00

A. Mhm-mhm. That was at the time of the investigation.

CHAIRPERSON: Yeah. So some people obviously weren't suspended, but there might be a protection plan and they'd be monitored. But were you not told who you were monitoring? 16:00

A. No. Ehm, you were given a monitoring form to fill in, but out of memory, I can't remember exactly, it was like a one page document and it was asking you, you know, overall, maybe four comments on it, and the last section was to fill in your overall view of how the care was during your shift that you were -- 16:01

CHAIRPERSON: So you were looking at the ward --

A. They were just generally of senior staff presence.

DR. MAXWELL: Was this the work that Moira Mannion was doing in collecting the forms? 16:01

A. Yes. Mhm-mhm.

DR. MAXWELL: Yeah. I think we've heard about that.

CHAIRPERSON: Yeah. Thank you.

144 Q. MS. BRIGGS: I want to go to another topic, and that's support for staff, and it's something we've touched on most of the afternoon. If we can go to page 23, paragraph 61? You are describing there the use of reflective practices for staff, which you say enabled them to sit in a safe space and discuss issues, like if they had a bad day or if they had encountered challenging behaviours, and you describe putting in place reflective practices in Donegore and Erne, and also you describe the use of clinical supervision twice a year, with more regular group supervision. 16:01 16:02

A. Mhm-mhm.

145 Q. From your discussions with your staff, those working beneath you, had that type of clinical supervision and reflective practice been offered to them before, or was it a bit of a novelty for them? 16:02

A. Ehm, definitely whenever I initiated it, that was the first that it had been done, and then it would later have been undertook right across the site, by I suppose more appropriate people than me, more skilled, psychologists, actually coming in and doing reflective practice, which happens regionally now in lots of facilities. 16:02

146 Q. And in terms of the formal clinical supervision twice a year on individual, on an individual basis. 16:02

A. Mhm-mhm.

147 Q. In the likes of Erne Ward where things were very poor, or had been very poor, was that enough? Did the staff need more do you think?

A. Ehm, well I suppose I was only there for six weeks, so I've no doubt they probably needed more regular supervision, you know.

148 Q. What about the second time around?

A. Ehm, yeah. I suppose there was a lot more of a positive team so, yeah. I mean clinical supervision arrangements were guided by the NMC in the professional guidance, and then for Band 3s I would have done clinical supervision for them as a group. It was something that they wouldn't have been used to before, do you know. So you would have had it as regularly as you needed to have. I suppose we also would have done things like incident debriefs, we would have held them once a week, so there was regular opportunities for the staff team to come together and review incidents in the ward and openly get some learning. 16:03 16:03 16:03

PROFESSOR MURPHY: So I'm wondering, you know, with a team like you had the first time you went to Erne, okay you were only there six weeks, but had you been there longer, do you think this kind of supervision and reflective practice would have been enough to turn their behaviour round? 16:04

A. Ehm, I suppose it would have been a start. To make cultural change it'll take a lot more than just lots of clinical supervision, do you know. Ehm, but, yeah, it would have been I suppose a start to try and address some of the key issues. 16:04

149 Q. MS. BRIGGS: H112, I'd like to ask you about a patient care topic, and I'd like to ask you as well about the

use of restrictive practices, all right.

A. Mhm-mhm.

150 Q. If we could go on to page 25, paragraph 68. You're describing at this paragraph, this is on page 25, how you would audit care plans and care recording, and one of the things or themes you would look at when you're conducting your audits is the use of restrictive practices, 16:05

A. Mhm-mhm.

151 Q. Presumably your audit relied upon the restrictive practices, or seclusion, or the like, being adequately recorded. 16:05

A. Mhm-mhm.

152 Q. Were you satisfied that those matters were being adequately recorded? 16:05

A. Ehm, well I suppose that's the purpose of any audit, ehm, you might find some things that you weren't happy with or could have been written better, but any concerns they would have had, they would have been learning opportunities, they wouldn't have been concerned about people's ability to write. I suppose I would have fed back to people, to the nurses, on auditing their care plans, to get some learning and, you know, articulate how they could have wrote things a bit better. And I suppose restrictive practice at that time, it was new language to us, so you were always trying to encourage people to use it in their daily recording, ehm, so that they could feel comfortable with it and be able to articulate it. So -- but not 16:05 16:06

concerns as such, it just would have been opportunities to learn.

153 Q. So on the whole then would you say that you were satisfied that when a restrictive practice was used it was recorded? 16:06

A. Absolutely. Yeah.

CHAIRPERSON: Can I just ask about that though, because there have been suggestions that patients have effectively been put into seclusion, but it's been suggested by way of example that they've gone there 16:06 voluntarily or they asked for a low stimulus environment. Would you expect that sort of thing to be recorded?

A. Absolutely, yeah. As I say, I didn't work in a ward with seclusion, other than my time in PICU, do you 16:07 know. Ehm, but, yeah, you would be recording somebody spending time in a low stimulus environment, yeah.

CHAIRPERSON: Of course, when you're doing your audit, you are relying on an accurate note being kept?

A. That's right. 16:07

CHAIRPERSON: Yeah.

154 Q. MS. BRIGGS: On the topic of patient records, if we could go to paragraph 70 on page 26, you're describing at this paragraph the PQC, Promoting Quality Care tool, which is a risk screening tool for patients. And if 16:07 patients exceeded a threshold, then a CRA would be carried out, and that's a Comprehensive Risk Assessment.

A. Mhm-mhm.

155 Q. You described earlier in your statement, and for reference it's paragraph 39, that none of the patients on Erne Ward when you were first there had a PQC carried out. So as a result, none of them had a CRA. Do you know why that hadn't been done in Erne Ward? 16:08

A. Ehm, my understanding and my recall was because the consultant didn't feel that they required it. The patients.

156 Q. The patients didn't require a CRA?

A. Yeah. 16:08

157 Q. But isn't the idea or what you understood that the tool had to be used first?

A. Yeah. Yeah, you're supposed to complete a risk screening tool to assess the need to progress to a comprehensive risk assessment, ehm, but some of these 16:08 patients were displaying high risk behaviours, and I felt absolutely they required a comprehensive risk assessment to manage that.

158 Q. But it hadn't been done because the consultant didn't think that they needed one? 16:09

A. Yeah.

159 Q. But did no-one think to say "Well, a PQC needs to be done first"?

A. Yeah. I don't know.

160 Q. What impact did that have on safeguarding? 16:09

A. Ehm, well, I suppose, you know, PQC, adult safeguarding, care planning, I always feel them three processes are really important to anybody's care, and they're all interlinked, you can't really have one

without the other. If you have someone that displays a high level of risk, then they're more likely to display challenging behaviours, they're more likely to have increase in adult safeguarding referrals, even patient-on-patient referrals. Ehm, so all them three factors is a really holistic assessment of somebody. 16:09

161 Q. And without that PQC, how does that affect --

A. Well, there's no risk management plan in place to effectively manage somebody who might be really risky and really challenging, or display behaviours of concern, and if these patients were going to the community I suppose it would have concerned me then that their placement might have broken down a lot quicker because the community provider wouldn't have had a comprehensive risk assessment in place to effectively manage any risky behaviours out in the community. 16:10 16:10

162 Q. If we could move on then to paragraph 76 on page 28, this is on the topic of seclusion. About halfway down that paragraph you're describing how patients were reviewed in seclusion, and you say that it used to be that a Band 7 staff member would have to review seclusion after one or two hours. 16:10

A. Mhm-mhm.

163 Q. But the policy changed over time and a registered nurse is now required to carry out continuous observation and stay outside the door the whole time that a patient is in seclusion. 16:10

A. Mhm-mhm.

164 Q. Just thinking about the old way, if I can put it that way.

A. Mhm-mhm.

165 Q. One or two hours does seem very long without a review, given that seclusion is meant to be for the shortest time possible. Would you agree with that? 16:11

A. Ehm, so I suppose the one or two hours, I think in terms of the policy, is a review by senior staff member. So there would have always been a staff supervising a patient in seclusion, but what changed was that that could have been a Band 3 healthcare support worker carrying out them levels of observations. Whereas now my understanding is that the policy is that it has to be carried out by a registered nurse. So I suppose they have a level of skill set and training to assess somebody in that enclosed environment. 16:11

166 Q. If we can go towards the very end of your statement now, okay? You were a Band 8A when you finished your career in Muckamore in 2019. 16:11

A. Mhm-mhm.

167 Q. And you reflect and you describe in great detail, and you have today as well, about what that role entailed and what leadership really entailed.

A. Mhm-mhm. 16:12

168 Q. And I just want to pick up on paragraphs 96 and 97, and this is on page 34. You're saying in those paragraphs that really you didn't, you don't recall receiving any formal support at Muckamore, but you say:

"I would have research best practice guidance and supportive processes to support the teams I led."

You say:

"I do not remember any formal pathways or leadership courses for the workforce. I did undertake a leadership course through the RCN, which I gained valuable experience. I did this course over a six month period and it helped with my leadership skills and overcoming barriers."

You say that the Belfast Trust paid for this and you did it one day a week, but you also say that you think you may have sought this course out yourself through the RCN website. And then at paragraph 97 you're saying that you don't recall any formal support from Human Resources.

All of your training and learning about best practice seems to have been undertaken by you, not with the assistance of Muckamore management, but kind of in spite of it. Is that a fair view?

A. Yeah. I suppose I was always very driven and passionate and always wanted to provide the best care, so I would spend a lot of time reading, and I was obsessed with reading RQIA inspection reports of other services across the region to get new ideas and to

learn of other in-patient facilities, yeah.

169 Q. So at some --

CHAIRPERSON: But did you get -- I'm so sorry.

MS. BRIGGS: Sorry, Chair.

CHAIRPERSON: But did you get protected time for that? Were you at least afforded the time when you wanted to go off and do some learning, or did you have to do it as part of your -- 16:13

A. Well you would be afforded the time for that. Like that example I gave of the course in the RCN, the leadership course, so obviously you would have been released out of your shift, yeah, to attend that. 16:14

CHAIRPERSON: Yeah. But it was you seeking that sort of training?

A. Yes, the RCN, they would issue professional courses that you can seek out and then you ask the Trust to pay for it, do you know. 16:14

PROFESSOR MURPHY: So MAH didn't prevent you from going on any courses you requested?

A. No, no. 16:14

PROFESSOR MURPHY: But they didn't ever offer you them? They never said "Oh, look, these courses are available"?

A. Not that I can remember. I'm sure there were. There was courses out there, I'm not saying there was never any training, do you know, absolutely there would have been courses available, but I don't recall anything beyond mandatory training that I didn't seek out myself. I suppose I gave some of them examples earlier 16:14

where additional courses I sought myself through the CEC for my staff team, they weren't ran by Muckamore as part of training.

DR. MAXWELL: Did you not have an annual personal development review? 16:15

A. Ehm....

DR. MAXWELL: So that -- I think that's in the policy, where somebody would discuss your performance over the last year and your development needs, and you might be expected to bring to that meeting what you thought your needs were and how you thought they could be met. 16:15

A. Yeah. Possibly sporadically throughout my career, yeah.

DR. MAXWELL: Okay.

CHAIRPERSON: Did it happen annually? 16:15

A. Yes. Well, yeah, they occurred annually. Sorry, I was going to say "manually". Ehm, I just don't recall, I suppose the value being attributed to them as it should, I suppose.

CHAIRPERSON: Yes. 16:15

170 Q. MS. BRIGGS: The very final thing I'll ask you about before I pass over to the Panel is the merger of Donegore and Killead Wards, and that's in 2018 when you were a Band 8A, and this is at paragraph 99, page 35, it's the last substantive paragraph of your statement. 16:16 You describe there the merger of the wards. You describe it as very difficult. You describe having to compile a lot of work regarding how the wards operated and present it in the boardroom. Before we move on to

that presentation that you gave, can you describe why it was the two wards were merged?

A. Ehm, I suppose my understanding of the merger was because Killead Ward, it was a massive ward environment, and they had really large open spaces, and they were possibly planning to close Erne perhaps and move some of the them patients in to Donegore and Killead, with segregated apartments in Killead to try and make it smaller physically. 16:16

171 Q. You describe having to work on the practicalities really of the merger and present the report in a boardroom, which was a mammoth task, and you say you were given about a week do it. 16:17

A. Mhm-mhm.

172 Q. You felt that there was little consultation with staff, patients and families about the merger. Why was it so rushed? 16:17

A. Ehm, I don't know, it just felt very rushed to me. I was tasked to calculate the staffing model for them two wards, which was quite a difficult task giving you two separate wards to amalgamate and, you know, how many beds were there? Didn't know the patient acuity, what that would look like. Ehm, I don't know to this day why that was rushed, but it needed to be done urgently. 16:17

173 Q. And who were you presenting your report to? 16:17

A. Quite a lot of people. Co-Directors, allied health professionals, psychologists. I assume it was -- I can't completely remember, but it must have been some of the multidisciplinary people involved in them two

wards perhaps.

174 Q. Okay. Were you ever involved in any other ward mergers or experience of ward mergers and how they were done?

A. No.

MS. BRIGGS: H112, that's all the questions I have for you. The Panel might have some. 16:18

A. Thank you.

CHAIRPERSON: We've asked the questions as we've gone along.

A. Okay. Thank you. 16:18

CHAIRPERSON: So, can I thank you very much for coming along to assist the Inquiry this afternoon, and it's been very informative and helpful, so thank you.

A. Thank you.

CHAIRPERSON: And you can now go with the Secretary to the Inquiry. Is it 10:00 o'clock tomorrow morning, I think? Just to say when I referred to learned counsel or solicitors in the room as "this lot", no discourtesy was intended. We'll see you tomorrow at 10:00 o'clock. Thank you. 16:18 16:19

THE INQUIRY ADJOURNED TO WEDNESDAY, 11TH SEPTEMBER 2024 AT 10:00 A.M.