MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 11TH SEPTEMBER 2024 - DAY 102

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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THE INQUIRY RESUMED ON WEDNESDAY, 11TH SEPTEMBER 2024, AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you.

MS. BERGIN: Good morning, Chair and Panel. This morning's witness is Mr. Bert Lewis, and he is content to be referred to by name. The internal statement reference is STM-306. Chair, there is a Restriction Order which applies to a short part of this witness's evidence. If we could please go into restricted session now so I can more fully explain that? 10:02 10:02

CHAIRPERSON: Yes, let's do that.

MS. BERGIN: Thank you,

CHAIRPERSON: Save that if I make a Restriction Order, which I can say I will, because I've read the relevant paragraphs, the order is effective. So we will go into closed session for these purposes. 10:03

MS. BERGIN: Yes. Thank you, Chair.

RESTRICTED SESSION 10:03

OPEN SESSION

MR. BERT LEWIS, HAVING BEEN SWORN, WAS EXAMINED BY MS. BERGIN AS FOLLOWS: 10:06

CHAIRPERSON: Mr. Lewis, good morning. Thank you very much for coming to assist the Inquiry.

A. Good morning.

CHAIRPERSON: Thank you for your statement, which obviously we've all read. I think you'll be a good part of the morning giving evidence. If you want a break at any stage just let me know, but normally we'll let you go for about an hour, an hour and a quarter, and then we'll take a break anyway. 10:06

A. Okay.

CHAIRPERSON: All right.

A. Yes. 10:06

CHAIRPERSON: So if at any stage you want to stop just let me know. Now I'll hand you over to counsel.

1 Q. MS. BERGIN: Thank you. Good morning, Mr. Lewis. We have met briefly, and as you know my name is Rachel Bergin, I'm one of the counsel to the Inquiry, and I've explained to you how we'll be dealing with your evidence this morning. 10:07

As I've already explained to you, we'll be dealing with the main part of your evidence now and then we will go into a closed session at the end, and if I could just remind you not to deal with those paragraphs 80 and 81, that I've already explained to you, until I make it clear that we're going into the closed session. 10:07

A. Okay. Yes. 10:07

2 Q. Okay? So in front of you, you should have two documents; a copy of your statement dated 10th July 2024.

A. Yes, I have.

3 Q. And also a cipher list. And if I could remind you when you're referring to any patients, relatives, or staff, if you could use the cipher and, if in doubt, please just write them down and the secretary can assist you.

A. Okay. Yes. 10:07

4 Q. And, finally, we have a stenographer in the room, so if I could ask you to please speak as slowly and clearly as you can into the microphone.

A. Okay. Yeah.

5 Q. So turning to your statement dated 10th July 2024, 10:07 you've signed the back page of that statement and the Declaration of Truth. Are you content to adopt that statement as your evidence to the Inquiry?

A. I am, yes.

6 Q. And if we could now then move to your statement, 10:08 please? And I've already explained to you that I won't be reading your statement aloud, but I'm going to very briefly summarise it and then I will be taking you to specific paragraphs to ask you about those.

10:08

So at paragraph 1 onwards you outline that you worked at Muckamore between 1989 and 2020, and you describe your initial training as a nurse, which included placements at Muckamore and other hospitals, and during your training at Muckamore there were induction 10:08 processes for each ward placement which lasted between six and 13 weeks?

A. Yes.

7 Q. And you had placements on Moyola Ward - CAPOG - which

was known as C2 Ward, and Moylena?

A. Yeah.

Q. And when you then qualified as a nurse in 1989, you worked as a Staff Nurse until 2001, and during this time you worked at Movilla A between 1989 and 1993; Fintona North between 1993 and 1999; Fintona South between 1999 and 2001, and then from 2001 you were a charge nurse, initially at Movilla A between 2001 and 2006, then on Cranfield Men's Ward between 2006 and 2017, and from 2017 until your retirement in 2020 you were seconded to the role of Day Services Manager. Is that all correct? 10:09 10:09

A. Yes. Ah-ha, yeah, that's all correct.

CHAIRPERSON: And can I just take it from your training. 10:09

A. Yes.

CHAIRPERSON: Had you decided at an early stage to focus on learning disability?

A. Yes, and I have referred to that in my statement. While I was at school during education I got involved through, it was the inter-schools charity committee, and was introduced to the Gateway Club in my local area, and that's where it gave me the interest within, you know, learning disability, and it was with advice from the careers teacher, and had give me options of employment within that field, so it was either through nursing or social work were the options into employment at that time. 10:10 10:10

CHAIRPERSON: And when you started - my colleague

Dr. Maxwell will know this - but when you started, was there a specific register for LD nursing?

A. There was, indeed, yes.

CHAIRPERSON: Thank you.

A. I think it was referred to mental handicap nursing at the time, as opposed to -- the terminology would have changed. 10:10

CHAIRPERSON: Has changed of course.

A. Through times, and rightly so.

CHAIRPERSON: Thank you. 10:10

9 Q. MS. BERGIN: You detail in your statement that most of your time at Muckamore was spent on admissions wards.

A. Yes.

10 Q. And you didn't work on resettlement wards at all?

A. That's correct, yeah. 10:11

11 Q. And you say that in terms of the admissions that you dealt with, you provide some detail to the Inquiry about various types of admissions that you had experience dealing with, including emergency and planned, and your experience working in those wards, including documenting and assessing risk, and that there were changes and formalisation of the risk assessment and documentation process around 2010? 10:11

A. That's correct, yeah.

12 Q. Those were under new promoting quality care guidelines where admissions then had new key workers who used a risk screening tool within 48 hours of admission? 10:11

A. Yes.

13 Q. And that risk assessments were reviewed by the MDT, the

multidisciplinary teams, and nursing and healthcare staff had access to these and to patient's individual care plans from then on?

A. Yeah, that's correct, yeah.

14 Q. And you deal with various matters in your statement, including training, use of seclusion and restrictive practices, auditing, and I'm going to be asking you about some of those now. 10:12

A. Okay. Yeah.

15 Q. But as I've said to you, the Inquiry has your full statement already. So if we could go to paragraph 15 to begin with, please. And here you describe working as part of a multidisciplinary team of nursing staff, psychologists, consultants, day care staff, and you say that in later years occupational therapists and behaviour services staff formed part of the MDT. When you say in the later years, can you orientate that in time somewhat? 10:12 10:12

A. Ehm, yes, I think as time went on, and particularly within my time spent within Cranfield Ward, there was more, more opportunities for sort of professional staff to be involved in patient's care, there was certainly much more resource available as opposed to in the early days, like back in Movilla A, whilst there was a multidisciplinary team it became sort of more robust and more cohesive as time went on. Ehm, you know, there was more of an input from psychology, from behaviour services staff, from, ehm, occupational therapists would have probably the last professionals 10:13 10:13

to come onboard. In terms of timescales, I wouldn't be exactly sure, but it would have been within the Cranfield period from 2006 onwards.

16 Q. And whenever you say that that was from 2006 onwards, you were in fact, and you detail this in your statement, involved in some of the preparations for getting Cranfield ready when it opened? 10:14

A. Absolutely.

17 Q. Yes. And was it your impression that those increases to the disciplines who were involved in the MDTs, including occupational therapists, was it your impression that those were, I suppose part of Cranfield opening and part of the new services there, or was it across the hospital that there was more a move towards inclusion of a wider discipline of specialists? 10:14 10:14

A. I think at that time there was more resource put into the core hospital as such, and that would have been within the opening of the Cranfield admission units and the forensic services within Six Mile as well came onboard around similar time. So there was -- certainly it was a new service as such that was being proposed and provided, you know, so it certainly was more inclusive. 10:14

DR. MAXWELL: Can I ask, did that reflect a different philosophy of care? Was the move to a new hospital with an expanded team part of a change in the way people thought about how people with learning disabilities should be treated? 10:15

A. Yes, I think whilst prior to the new units opening

there was good service provided, but unfortunately the buildings were wrong and weren't conducive to, you know, we were sort of large dayroom areas, locked dayrooms, dormitory situations, whereas this was all much more person-centred like, and it was a large move towards that type of care.

DR. MAXWELL: So I understand the estate wasn't very good.

A. No.

DR. MAXWELL: And it was nice to be in new buildings. 10:15

A. Yeah.

DR. MAXWELL: But you also talked about having a wider range of professions.

A. Yeah.

DR. MAXWELL: And you just said then a move to a person-centred approach to care, was that, and I'm not saying there's anything wrong with the care before, was this a new approach? Were you moving to a new philosophy of care? Not meaning there was anything wrong with the old one. 10:16

A. No, no, no, I certainly understand it, and it wouldn't, it wouldn't have been a total change, there was progression before the new units opened.

DR. MAXWELL: Mmm.

A. But I think that was the catalyst to move things on that bit further. And there certainly was much more resource put into services. 10:16

PROFESSOR MURPHY: We've heard from other witnesses that there is settlement wards, or certainly some of

them were rather neglected, both from the point of view of MDTs, but also from the point of view of buildings and resources. What was your view? I know you didn't work on them, but presumably you talked to people who did? 10:17

A. Yeah, ehm, and we would have had meetings across the site that included the charge nurses and Ward Sisters from both resettlement and from the core hospital.

PROFESSOR MURPHY: Mhm-mhm.

A. It certainly would have been my experience that there was, at that time around 2006, there was more resource put into the core hospital in terms of professional staff. There was more hours, there was more psychology, there was dedicated social work staff for each unit. Ehm, so whilst the resettlement wards certainly did have resource, it was more concentrated towards the core hospital at that time. 10:17 10:17

PROFESSOR MURPHY: Thank you.

CHAIRPERSON: And was there a different way of bringing the other disciplines in? In other words, dealing with psychologists or perhaps OTs, did you now find them more on the wards than they would have been before? 10:17

A. Absolutely. Yeah, yeah. And I think the facilities of the new units provided that as well. There certainly was much more accommodation, there was more offices available where staff could consult, you know, with patients. The environment itself was conducive to, you know, professional staff coming in and meeting with patients within day areas and day spaces. 10:18

CHAIRPERSON: Yeah. Okay.

A. Whereas before it was quite -- in two out of the three wards I worked in with Movilla A and Fintona, they were locked environments. And while Cranfield, the front door to the unit into the unit was locked, beyond that it was very open and spacious. 10:18

CHAIRPERSON: Yeah. And prior to this change, were you aware of OTs in the hospital at all?

A. I don't believe they were available at that time.

CHAIRPERSON: Psychologists would have been. 10:19

A. Psychologists would have been, yes, yes. And they would have been involved in the care within Movilla.

CHAIRPERSON: And when you refer to behaviour services staff, can you just explain to me what that means?

A. Yeah. Well, there was -- the behaviour staff within my experience were predominantly nursing staff that went on and done, you know, further university qualifications. 10:19

CHAIRPERSON: Yeah.

A. They travelled across the water to England, I'm not exactly sure of what university it was, but -- and we had a behaviour staff then was associated to each ward. Prior to that there was behaviour, a behavioural department, but it dealt with taking people from the ward that they were residing in, into like a day opportunity, you know. 10:19

CHAIRPERSON: Right. So again it became more ward focused.

A. Yeah, more ward based, and certainly much more

integrated within the service.

CHAIRPERSON: Okay. Thank you.

DR. MAXWELL: And when did the behaviour nurse role start? Was that there from the start of your training or... 10:20

A. No, no, that would have been -- well there was behaviour staff and they would have been nurses, but I don't believe that they had extra qualifications at that stage.

DR. MAXWELL: So when did they start going to England to do this course, roughly? 10:20

A. Ehm, it would have been probably the late '90s, 1990s. Ehm, there was just one colleague had went when I worked in Fintona North, so that would have been between '93 and '99 that had went and done the course, and then continued working as a nurse on the ward for a while but then moved sideways into behaviour services. 10:20

DR. MAXWELL: And are you saying that around the same time as the core hospital opened you moved to having a behaviour nurse attached to each ward? 10:20

A. Yeah. Yes, that's correct. Yeah.

18 Q. MS. BERGIN: Yes, thank you. So picking back up then on some of the themes that the Panel explored with you around what you've actually said in your statement at paragraph 19, which is there was a move to person-centred care. Further on in paragraph 19 you then say that: 10:21

"...this resulted in a more individualised approach and

this obviously required additional staffing resources to deliver and staff/patient ratio improved dramatically throughout time."

So when you say that this staff to patient ratio dramatically improved, what time period are you talking about there? 10:21

A. Ehm, well I suppose when I first took up employment as an example in 1989, there were four staff per shift on the admission unit, two of which would have been trained and two were untrained. But through the time then I, I went back in 2001 to the same unit, the resource would have been maybe seven, eight staff per shift. Ehm, so over that period of time it increased dramatically. Ehm, now there was changes in the level of supervision that was provided to patients, one-to-one nursing became much more of a tool that was used to supervise patients and ensure safety. And the skill mix of the nursing staff improved as well during time. When I left Cranfield in 2017, the nursing staff, trained to untrained, would have been 60 to 40%, whereas that would have been the opposite of that in the early days when I worked like. 10:21 10:22 10:22

19 Q. Yes. And you in fact detail that at paragraph 41 of your statement in terms of that increase in skill mix? 10:23

A. Yeah, yeah.

20 Q. The Inquiry has heard from other witnesses that staffing numbers, and at times the skill mix of staff was a major problem, particularly following staff

suspensions after the allegations of abuse came to light in 2017?

A. Yeah.

21 Q. And that RQIA had served Improvement Notices, one of those relating to staffing. Did you find staffing to be an issue that impacted care that was provided at Muckamore? 10:23

A. From 2017 or prior to it?

22 Q. At all stages that your were there?

A. Ehm, well certainly in the wards that I managed, priority was given to patient care, and that would have -- there was other things that were, I suppose, set to the wayside, like you know. In the ideal world we would have had resource to do everything we wanted to do, but in terms of possibly training, and I think I've referred to that within my statement, like you know -- 10:23 10:24

23 Q. Yes, you have, at paragraph 67?

A. Yeah. We certainly would have, on a daily basis, cancelled training as opposed to leave a ward short where patient safety was compromised. 10:24

24 Q. When you say "on a daily basis", how frequently would training have had to be cancelled for staff because there were staff shortages?

A. Ehm, it wouldn't have been unusual, and I suppose there were peaks and troughs within that, and it would have been down to, I suppose casual or short-term sickness would have been the biggest impact on that. What we did to try to mitigate against that was the planned training well in advance of when it was actually due. 10:24

So if it was mandatory training and there was a timescale of 12 months, we would have arranged for the training to be that wee bit earlier so that that gave a contingency so that staff were still working within the parameters of having their training kept up-to-date. But if it was cancelled for whatever reason, then they were still safe to practice until it was rearranged.

DR. MAXWELL: Can I ask you a little bit more how you organised the care on the ward.

A. Yes. 10:25

DR. MAXWELL: Because we have heard about periods when there were very significant staff shortages. So in 2012, staffing shortages were on the Risk Register, so there had been periods over time. And you talk about the move from task orientated to patient centred care. 10:25

A. Yeah, yeah.

DR. MAXWELL: But when you lack staff, if you've got vacancies or absences, one of the ways to make sure that the fundamentals, the essential care gets done, is through task allocation, and we have heard witnesses say that there would be a task allocation sheet on the wards. 10:26

A. Yeah, yeah, yeah.

DR. MAXWELL: So the healthcare assistants in particular would know which were their tasks. 10:26

A. Yeah, yeah.

DR. MAXWELL: That seems to work against this change in philosophy towards holistic person-centred care. So to what extent were you able to move to this new approach

of holistic care when you were having to rely on task orientation?

A. Yeah. Well I think both systems had to work hand-in-hand. Because it was a hospital environment and there were certain activities that were core activities that had to happen, ehm, you know, in terms of say for a registered nurse having to give medication out at a certain time, so that had to be sort of delegated like, because if we had four nurses on, four trained nurses, we had to ensure that it was the one nurse was doing that task, as opposed to -- and that would have provided, you know a safeguard that medication was given, that it was one person's responsibility. 10:26 10:27

In terms of -- we would have then allocated our nursing staff, both our trained nurses and unregistered nurses, to provide care then to specific patients or specific small groups of patients, and that's how we, I suppose, developed the person-centred care along with the care planning, and within that then there were certain activities that became essential, like named nurses having a responsibility of meeting with their patients at least on a weekly basis, documenting that communication. 10:27 10:28

DR. MAXWELL: So coming back to the daily work, so the healthcare assistants would be given a list of tasks, and did they work in teams? Did they have patient allocation or team allocation?

A. Ehm, within, and I suppose more specifically within Cranfield, we had the resource to "buddy up" a healthcare worker along with a Registrant, you know, so that they would have been looking after a particular group of patients maybe, and the groups were small. 10:28

DR. MAXWELL: Yeah.

A. It was a 14-bedded unit.

DR. MAXWELL: So in a lot of areas of nursing, people talk about the pressure to get the work done before the next shift, you know this is long... 10:28

A. Yeah. Yeah.

DR. MAXWELL: For healthcare assistants that often means getting all the personal care, the washing, the shaving --

A. Yes, yes, yes. 10:29

DR. MAXWELL: -- done before lunch. Was there that sort of pressure? If a patient didn't want to get up, did the healthcare assistants fell under pressure to get that work done?

A. Absolutely not, no. That choice was given, you know, and we did have patients in various stages of their illness or their recovery that required, you know, more time to undertake those, you know, the personal hygiene and the bathing and that type of thing. We were very flexible. But the environment leant to that as well, because the area -- and I'm sure youse have probably seen round Cranfield, you know, and there was a staff base, and then off that was several rooms where the observation was very good, you know, and staff could 10:29 10:29

see when patients, you know -- they did have a patient call system which they used if they were able to, but then were able to see when patients came out of bedrooms as well. So the environment leant to, you know, allowing patients, you know, the time to get up of their own accord and, you know. So it was very flexible.

DR. MAXWELL: Thank you.

25 Q. MS. BERGIN: Thank you. If we could look at paragraph 24 then? I'm going to come back and ask you about activities in a moment, but if we just look at paragraph 24, please, first? 10:30

A. Yeah.

26 Q. So you've already indicated that you weren't involved directly on resettlement wards? 10:30

A. Yes.

27 Q. But here you say that you would have been aware of when patients were ready for decision charge and contributed to discussions about this, and you say that MDT meetings were held in Cranfield in particular, and you refer to a Service Improvement Project? 10:30

A. Yeah.

28 Q. Which introduced several specific meetings to discuss discharge and resettlement. And you say further down that: 10:30

"Sometimes the post-admission meeting turned into the discharge meeting as we did not want people to spend a lot of time in Muckamore if they did not need to be

there. I contributed and attended these meetings."

Can you explain to us what your role at those meetings was?

A. Ehm, well, it was given the nursing perspective and giving a summary of the patient's presentation. So if it was a post admission meeting we had it set up then that we would have families were invited, community staff were invited, and they would sort of paint the picture of what led to admission. My responsibilities then at the meeting would be to give a synopsis of how the patient had been since admission and what progress they had made. And then other disciplines would have been involved and gave, you know, to give a full picture. I suppose I'm not really sure what else, you know, I'm maybe being a bit generic there. 10:31 10:31 10:31

29 Q. Well, I'll ask you further questions about it.

A. Yeah.

30 Q. So in terms of the Service Improvement Project which introduced, you say, several specific meetings. 10:32

A. Yeah.

31 Q. Your involvement as a nurse in these types of meetings, is that something that had always been the case or is that something that was introduced by the Service Improvement Project? 10:32

A. No, no, no, no. Ehm, nursing staff were always involved and were a core participant within multidisciplinary team meetings.

32 Q. And what was --

A. I suppose the Service Improvement Project gave a framework and set out what the minimum standards were for admission, admission units, and it gave clarity on, you know, and expectations for families and patients of what to expect next and what the process was. So the first part of that would have been the post-admission meeting. After that then we held progress meetings and updated patients and families who were invited to those meetings, along with the community team. So it included, you know, it gave inclusion, like you know, and sort of gave that continuity between community and hospital care. So that it wasn't just all of a sudden, you know, that professional staff from the community were involved again because somebody we were talking about discharge. 10:32 10:33 10:33

33 Q. When did that Service Improvement Project occur or take effect?

A. I think it actually started prior to the new hospital opening in 2006, but it was maybe just a year, but I think it was actually a proposal that this was how the new service would work, but it was introduced within Movilla A before moving over, so that I suppose we weren't going into something totally new, you know, and we had a bit of a grounding in this new process. It was always the case that we met with families and we met with community teams, but I think this was just putting that framework in place which, you know, created or allowed expectations to be met. 10:33 10:34

PROFESSOR MURPHY: You say that it was partly to inform

the families. So how did they get to know about this service improvement plan? Did you have a leaflet that was given out to families or how did you do it?

A. I'm not sure about the introduction of the -- but what we talked about on admission, we did have -- certainly within Cranfield we had a brochure which described the patient journey throughout what we expect, or what their expectations could be during their admission journey within the hospital, and it was outlined within that brochure. So that was given on admission to families, or as soon after as possible. The community teams also held copies of that brochure as well so they were maybe able to prepare patients and families prior to admission. 10:34 10:34

PROFESSOR MURPHY: Thank you. 10:35

34 Q. MS. BERGIN: You refer at paragraph 25 on the same topic to a checklist for discharge.

A. Yeah.

35 Q. As part of those procedures and guidance that followed that review. Is that something that as time progressed, and as you've previously indicated in your evidence further disciplines were involved, that meant that your role at attending discharge meetings was reduced? 10:35

A. No. That certainly wasn't reduced. I think what actually happened in time was that it was the correct professional doing the correct part of the process. 10:35

36 Q. So perhaps clarified?

A. Yeah, yeah. But, no, no, certainly nursing staff were

always involved in all the meetings that we held for patients within Cranfield.

37 Q. And, for example, the checklist for discharge, is that something that essentially was an action plan that yourself and other members of the multidisciplinary team all had responsibility to ensure was being adhered to to prepare a patient for discharge, or how was responsibility divided? 10:36

A. Well certainly it would have been my responsibility as a charge nurse for the unit to sign off on it and ensure that everything was completed prior to discharge, and that would have meant engaging with other professional staff and ensuring that their -- like for example, the social work had already, if sometimes when patients went to new environments from they were admitted, there was -- their benefits and that had to be sorted prior to going, and that there was enough finance in place. Ehm, so it was my role to ensure that that, that the social work had that completed like and then we signed off on that. But it was, the checklist was set out in a way that it was what to do four weeks beforehand, what three weeks, what two weeks, what to do on the day of discharge. So it included the practical things that the patient had a physical examination from a medical officer prior to discharge to ensure they were medically fit to leave the hospital. That's just as an example. But it would have included tasks like, you know, ensuring the patient's clothing was collected and documented like 10:36 10:36 10:36 10:37

and went home with the patient.

38 Q. Okay. If we could move then on to activities for patients, and I appreciate we're jumping around somewhat, but if we could go to paragraph 22, please? Here you say: 10:37

"I found each of the wards I worked on as a Staff Nurse to be very similar. There was a strong emphasis on activities for patients and this was led by the senior staff on each ward." 10:37

Then you go on to say that the charge nurses and Ward Sisters were involved in the day-to-day care of patients, and you were very much influenced by their commitment to patient care. 10:38

When you refer to activities for patients here, do you mean activities on or off the wards?

A. It's a combination of both, you know, certainly if patients were able to and wanted to go to day care, 10:38 that that was facilitated. But on top of that then there was activities on the ward as well, you know, and I think in time that developed further and we were able to bring in - there was additional resource made available and we brought more therapists into the 10:38 environment, into the ward environment. So certainly in the early days, you know, like in my early days of working within Movilla there would have been day care staff came into the ward and had paraparetic sessions,

and they would have been, sometimes they would have been basic literacy, they might have been recreational activities, but there was a programme within Movilla A, and that was for patients who were unable to leave the ward due to the, I suppose where they were in their admission, or for some individuals who chose not to leave the ward. But activities were offered to them. There was specific area within Movilla that was set aside for activities, and that was encouraged by the charge nurse. 10:39

DR. MAXWELL: And what sort of activities could they do on the ward?

A. Ehm, well it would have been art and craft sessions. There was we had one -- I think day care staff at that time didn't have any specific qualifications, but they had interests which they used and, you know, their managers obviously utilised. So if they had an interest in education, like whether it was basic English and maths, you know, that we had sessions for that. We had people who were interested in music that brought in guitars and, you know, would have, you know, encouraged, you know, sing-alongs and that type of thing. But it was a very specific programme within Movilla A, because at that time there was quite a few of the patients that didn't leave the ward that had, you know, they had to be ward based. 10:39 10:40 10:40

PROFESSOR MURPHY: Because that was the elderly ward?

A. That was -- no, no, it wasn't the elderly ward. It was the admission ward.

PROFESSOR MURPHY: Okay.

A. But unfortunately it was a dual purpose ward. It was seen as a semi-secure unit as well. So prior to forensic services being properly introduced in later years, there was a mix of patients within the ward. So some of the forensic patients, or patients with a forensic history, weren't able to avail of day care at that particular time. Again, as services improved and moved forward that wasn't the case like, you know. 10:40

CHAIRPERSON: Could I just ask, when a patient was able to go to the day care centre, was there a programme for each patient that they'll be going, you know, "X will be going on a Tuesday and a Thursday", or was it just at will? How did it work? 10:41

A. I think again referring to probably the '90s onwards, ehm, each patient -- there was -- a referral was made by the multidisciplinary team at the weekly ward round, which day care staff were present at, and they had already had a pen picture of the patient and thought there was several different departments within day care within the hospital. So they would have allocated then a key worker to come over and meet the patient and meet the staff and work out which was the best environment for them to go to. So there was areas called "work skills" which would have been more able, and it was based around a lot of sort of contract tasks, but then recreational activities built into that, into the timetable. So patients would have went between five and eight sessions per week. 10:41 10:41 10:42

CHAIRPERSON: And a session would be half a day?
A. Where a session would have been a morning or an afternoon.
CHAIRPERSON: Yes.
A. But day care always broke up at lunchtime, so patients returned to the ward for their lunch, ehm, and then went back again after lunch like, and that was escorted by nursing staff. 10:42
CHAIRPERSON: But you also said if a patient made a specific request? 10:42
A. Yeah, yeah.
CHAIRPERSON: Could that be facilitated?
A. Absolutely. Yeah. And I think as, you know later on maybe in my statement, in my evidence, when I took over the role of Day Services Manager, I suppose it was an opportune time, because there was an ongoing review of the service when I took over, and it identified a lot of areas that needed improvement, and one of the things that we developed was having a drop-in for each activity. So we had an open swimming session, open artwork, open -- we created a gym within, you know, within the environment. So patients -- and that wasn't timetabled, but patients then could chose to come and dip in and dip out of activities that they wanted to, without being, you know, it being "Oh, you have to go to day care at a certain time", like you know. 10:42 10:43 10:43
CHAIRPERSON: And while -- sorry, Ms. Bergin is probably going to go to this anyway, but while we're on this topic. After the 2017 allegations came out and

staff began to be suspended.

A. Yeah.

CHAIRPERSON: And the hospital was obviously significantly disrupted.

A. Yeah. 10:44

CHAIRPERSON: Did that significantly affect the opportunities for day care as well?

A. I can't say that it 100% didn't, but day services seemed to be quite removed from the allegations that were made. There ended up one or two staff were -- 10:44
well, I think in my time there was a total of three staff were suspended, but they were suspended following something being viewed on CCTV on the wards, you know, where they worked as maybe bank nurses as well as their day care employment. 10:44

CHAIRPERSON: Oh, I see.

A. So it was dual employment. So the resource within day services was very good like.

CHAIRPERSON: And continued through the --

A. And we -- it didn't impact the way that we seen it 10:44
happening on the wards.

PROFESSOR MURPHY: Did you have CCTV in day services?

A. We didn't originally when I took over in 2017, but it was proposed. I think it came in around 2018 within the main day services building and the swimming pool 10:45
within the hospital as well, within all the group rooms and the communal areas.

PROFESSOR MURPHY: But on the whole it sounds like what you're saying is that in day services, even before

there was CCTV, on the whole there was very little challenging behaviour because people were occupied.

A. Yeah. People chose -- the patients chose to come to day care, they wanted to be there.

PROFESSOR MURPHY: Yeah. 10:45

A. Whereas they maybe didn't want to be in hospital. So they were upset about being in a ward and, you know, we were - day care was always smaller numbers like, so there'd have been more nursing, or the ratio nursing of staff to patients wouldn't have been as good as what it 10:46 would have been within day care.

The facilities within day care were fantastic in terms of the amount of space, so the group rooms were very big and the numbers were - my experience would have 10:46 been I suppose it was a maximum of four or five people in a group, along with a day care worker and an assistant, you know, a healthcare worker. We also would have had support from - the ward staff would have came over if somebody was on a specific level of 10:46 observation. So they'd have been responsible for that part of their care, whereas we had then resource within day care workers to provide the activity for the patient.

PROFESSOR MURPHY: Yes. 10:46

A. So choice was fantastic. I remember an example when I went over and there was four patients in a room receiving their day care and they were having their break, and all four individuals were having something

different for their break, because that was their choice and that's what they asked for. So to me it was a perfect example of person-centred care.

39 Q. MS. BERGIN: Yes. And you actually say in your statement at paragraphs 26 and 27 that there was a dramatic improvement in both the range and quality of services at day care, and in addition to the types of services that you've already given evidence about... 10:47

A. Yeah.

40 Q. It's correct that there was also an increase in the times when day care was available? 10:47

A. Yeah.

41 Q. So it wasn't nine to five, it was into the evenings and at the weekends as well. Is that correct?

A. Yeah. Ehm, it was the -- well, they called it a seven day services, one of the things that we implemented. And so instead of just traditional groups then, there was activities in the evening, and that might have included, you know, like a sporting activity, it could have been going to, you know, having an outing 10:47 10:48 somewhere. You know, they held cookery clubs in the evening time. And, again, these were open sessions, you know, that any of the patients from any of the wards, whether it was resettlement or core hospital, could have attended. So the choice, the choice was 10:48 there, and invariably they were well attended. At the weekends what we done was we would have had between four and five day services staff available that would have went in and supported patients directly on the

wards and took them out, maybe took them over to an activity, whether that be swimming. We provided bicycles. Ehm, the hospital management did purchase two additional vehicles for the site, which both nursing and day services staff used to take patients out, you know, to the local community. Also within I suppose our review of the services, there was a lot of move to community activities. We developed a link with another, a day centre within the Belfast Trust, and our patients would have visited there one day a week and took part in activities, and also some of their patients came up and took part in sort of special events within the hospital that we were holding, you know, around holiday time and like Halloween and Christmas and that. So... 10:48 10:49 10:49

42 Q. If we could move to paragraph 34, please? And here you say that during your time as a Staff Nurse, and that was between 1989 and 2001, you were responsible for developing care plans for specific patients in conjunction with the MDT, and you refer to the use of Roper, Logan and Tierney model, which the Inquiry has heard some about before -- 10:49

A. Okay.

43 Q. -- to help assess and plan patient care. Then you go on at paragraph 35 to say that: 10:50

"I was involved in various aspects of the treatment of patients. All of the treatment plans were developed at the MDT meetings. There were a lot of facets to the

treatment plans."

- and you list those, including medication and supervisions, occupational therapy and physiotherapy needs, and day care services. 10:50

A. Yeah.

44 Q. And, if required, patients were placed on enhanced levels of supervision.

Now, the Inquiry has heard evidence about the introduction and use of Positive Behaviour Support plans, you don't refer to that there in your statement. Is that something that was an aspect of the care plans? 10:50

A. Absolutely. Yeah, yeah. Ehm, I don't know why I omitted it like from the statement, it was maybe an oversight, but it certainly did feed into every patient's care plan, especially in the last sort of five to six years of my employment within the hospital. So all our staff received, you know, from our healthcare workers and our registrants, like you know, received Positive Behaviour Support training, you know. And it was at different levels for different grades like, you know. It was more, I suppose more in-depth for our registrants, but everyone at least had an oversight of what Positive Behaviour Support was, and that was provided in-house by the behaviour nurses within the hospital in conjunction with the psychology team. 10:50 10:51 10:51

45 Q. When you refer to that being something that was in

place in the last to five six years when you were in the hospital...

A. Yes.

46 Q. Is it correct that the PBS plans were brought in more recently? They weren't a feature throughout the entire time that you were a nurse at Muckamore? 10:51

A. No, absolutely, no. They were -- it was in the later years certainly.

47 Q. How -- in your personal experience, how did you find that the use of the PBS plans was received by staff and actually implemented in practice on the wards? 10:52

A. Yeah, it certainly was something that I encouraged my team, and they did embrace it. I suppose there was only one difficulty that we had with the Positive Behaviour Support plans were that they were separate from the nursing care plan, in that -- and that was a practical thing. When the PARIS system was introduced there wasn't availability for the Positive Behaviour Support plan to go on to that document, so it actually sat outside. So people had to refer to the electronic care system, which was the PARIS model at that time, and then have a paper record of what the - the behaviour support. So. And it was a practical thing, it wasn't -- it was -- it wasn't seen, it wasn't seen that -- everybody embraced that it should be inclusive, but it was practical from a point of view that you just couldn't put certain things on to PARIS, it had to be developed because it was, I don't know the ins and outs of it like, but it was an electronic system. So it was 10:52 10:52 10:53

thought about in terms of the risk screening tool was the specific part of the PARIS system and it was, you know, an area where, you know, you could go specifically within the care plan, but that wasn't developed for Positive Behaviour Support like. And it wasn't seen as an oversight, I think it was at the development stage of PARIS, Positive Behaviour Support plans weren't thought to be the, you know, a core area of somebody's care. 10:53

PROFESSOR MURPHY: And by the time you finished in 2020, was that still the case that these were two separate documents? 10:54

A. Yeah, yeah. It was, yeah.

DR. MAXWELL: The Inquiry has heard that some staff felt that sometimes the Positive Behaviour Support approach was risky, because previously if somebody's behaviour had not been as desired there would have been a consequence, so that would have been enforced behaviour. 10:54

A. Yeah. 10:54

DR. MAXWELL: And the Inquiry has heard that some staff felt that there were risks associated with not immediately responding to the behaviour, but actually trying to understand what had motivated that. Did you find staff were concerned about whether that would. 10:54

A. I think it was learning for staff, you know. It was a very different approach to what had been in the hospital at a time.

DR. MAXWELL: Yeah.

A. And you talk about that, you know, an example might have been if a patient presented with risk and had been violent or aggressive. You know, previously it would have been thought, well, that risk is too high to bring that person out on an outing, but there was certainly the shift then within Positive Behaviour Support, you know, that the approach was that what you said about understanding why the behaviour happened like, you know. And if you take that part away from it, why would the patient miss out on an activity that is going to engage them and divert them or whatever.

DR. MAXWELL: But in terms of, if you've worked at Muckamore for 20 years.

A. Yeah. Yeah.

DR. MAXWELL: And your 20 years has been about risk containment, is it not quite a big leap to then say, "Actually, no, we're going to be much more tolerant of risk"? Is that hard for staff to make that change?

A. Yeah, I think it is. But, you know, the encouragement that staff got, and seen, I suppose, the benefits of that, you know, it wasn't an overnight thing, you know, it took several years to embed into practice.

DR. MAXWELL: Was there a difference -- you talked about different levels of training, the registrants got a more extensive and higher level training.

A. Yeah.

DR. MAXWELL: Was there a difference in the attitude between the healthcare assistants who had probably had less training in this new approach and the registered

nurses?

A. I think that they needed more encouragement and needed more support and more advice on it.

DR. MAXWELL: So it might have taken them longer to come around to this approach than the registrants. 10:56

A. Yeah, it took them that wee bit longer, yeah. Yes. Yeah.

DR. MAXWELL: Thank you.

48 Q. MS. BERGIN: If we could move to paragraph 37, please? And here you say that, at the bottom of the paragraph, 10:57 after referring to the fact that patients had identified named nurses, and that you, whenever you were a Staff Nurse at Movilla A and Fintona, had no more than four patients at a given time.

A. Yeah. 10:57

49 Q. You then go on to say that:

"As a charge nurse in Movilla A and Cranfield wards, I ensured that each patient had a named nurse, each patient's care plan was individual, where possible had 10:57 patient involvement, included family/carer input, and each patient had a documented weekly one-to-one private time with their named nurse or identified deputy."

And I'll come on to the subject of audits in a moment, 10:57 but you also refer then to being involved in conducting a minimum of two care plan audits per month?

A. Yeah.

50 Q. So in relation to the care plans, I wanted to ask you,

how did you involve patients and how did you involve families in that process throughout that time?

A. Yeah. Well, I think it's just in the way that they would be involved in any of their care. The care plan was discussed with the family, it formed part of the discussion on admission, and probably the most important information we got on admission was from patients and from families themselves. It wasn't always possible for families to be there, because it could be quite a distressing time for relatives when their son or their daughter was being admitted to hospital, and it actually worked better, but it didn't happen too often. If we could have a meeting with families prior to admission, where the admission was planned, and the quality of the information we received, and that we could then, you know, return to the family like, was more important. 10:58 10:58 10:59

So in terms of when it was paper records, you know, families would have -- there was a document within the care plan that relatives, that they had viewed the care plan and signed off that they had read the care plan. Again, the same thing was available for patients if they were able. 10:59

Electronically wise, we had to just record that the care plan was shared with family. There wasn't the availability of them signing the electronic record that they had reviewed it and viewed it.

51 Q. So following admission in that initial care plan process that you've described, what about ongoing involvement?

A. Yeah.

52 Q. Presumably there were changes to care plans over time, so how were families kept involved? 11:00

A. Yeah. That would have been the responsibility of the named nurse then to share ongoing progress and changes within the care plan, you know, with relatives. We had then -- there was a pro forma developed that we used after each multidisciplinary team meeting, where nursing staff then fed back to patients and to their relatives after each weekly MDT meeting. And, again, whilst the families themselves didn't have an opportunity to sign that as such, it was recorded then that it was discussed with the families and what their views were. There was also an opportunity prior to an MDT where families were contacted, in they chose to be that involved in their relative's care. Some didn't, you know the majority did, but some didn't. So they would have -- if they had something they wanted to discuss. And then I suppose my last sort of year or two years, families were invited to the weekly multidisciplinary team meeting. Quite a few choose not to, because with a ward with 14 patients and, you know, it was very time limited like, so what actually happened in practice was that families met outside that with the core professionals, with consultants, and made appointments through that system.

53 Q. So if there were changes to a care plan, irrespective of whether a family had expressed an interest before the MDT, in terms of providing input, would families have been informed if there were changes to care plans then along the way? 11:01

A. Ehm, I suppose if it was major changes, yes, they would be, they'd be informed on a weekly basis as part of that feedback from the MDT, because the care plans changed as a result of having an MDT meeting. It could have been starting a new medication, it could have been 11:02 being referred to day services or involvement of referrals to other health professionals.

54 Q. Was there any formalisation of that process? You said earlier that it generally fell to the Staff Nurse to do that. Was there any formalisation if there was a 11:02 particular level of change or a type of change that it fell to a particular member of the MDT to ensure that the family were informed?

A. Only that the nurse responsible, or the nurse who attended the ward meeting had responsibility then to 11:02 feed that back as part of their - before they went off duty that day. And what we did to facilitate that was to make that nurse supernumerary for the day so that they weren't involved in other, you know, patient, direct patient care for the duration of their shift. 11:02 So they would have worked the nine to five on the day of multidisciplinary team meeting. So they had to go through -- now if -- there would have been occasions where they never, maybe never got hold of relatives, if

relative were working, or busy, or whatever, and then that would have been communicated through the staff handovers for somebody else to do that.

DR. MAXWELL: Can I just clarify? So there'd be one nurse allocated on the off duty to attend the MDT meeting? 11:03

A. Yeah.

DR. MAXWELL: It wouldn't be the named nurse for the patient, this would be one nurse...

A. Yeah. 11:03

DR. MAXWELL: Reporting for all patients.

A. Yeah.

DR. MAXWELL: And they weren't doing any clinical duties that day?

A. That's right, yeah. 11:03

DR. MAXWELL: They would prepare for, attend, and then give the feedback after the MDT?

A. Yeah, yeah. Practically it wouldn't have been possible to have every named nurse in, you know.

DR. MAXWELL: No, I understand. I understand. 11:03

A. And that was only the way that we could, you know, when it came to the progress meetings that were held periodically throughout the patient's stay with the Cranfield Ward, named nurses would have attended those meetings like, so it was more in-depth. 11:04

DR. MAXWELL: What's a progress meeting?

A. A progress meeting would be so somebody who was admitted into hospital had their post-admission meeting, weren't ready for discharge, but to keep

everybody, keep the community team engaged and to keep relatives and patients updated, then we had progress meetings. So as a minimum within Cranfield we held it, it was every six weeks. Or more necessary if -- and I suppose that included, you know, you know it was sort of increased discharge planning and, you know, if new providers came onboard.

DR. MAXWELL: So there'd be the weekly MDT meeting.

A. Yeah.

DR. MAXWELL: And then every six weeks each patient would have a progress meeting? 11:04

A. Yeah.

DR. MAXWELL: Where the named nurse, the person who was responsible for the overview of that patient on the ward would be present, and the family would be invited? 11:05

A. Yeah, they'd be invited to that. And it was social work staff that done the invitations at that time, they coordinated that. Six weeks was sort of a minimum.

DR. MAXWELL: Yeah. It could be more?

A. But if there was nothing, no big changes in the patient's care, you know, we didn't bring relatives up just to say that. That could have been done over the phone. 11:05

DR. MAXWELL: But they would know there was going to be a progress meeting? 11:05

A. Yeah, absolutely. Yeah. You usually set the date at the, you know, at the post-admission meeting, the consultant would have said like "We'll meet again in six weeks", and --

DR. MAXWELL: So just to get the chronology. My relative is admitted.

A. Yeah.

DR. MAXWELL: There's a post-admission meeting that I'm invited to. 11:05

A. Yeah.

DR. MAXWELL: When would that be?

A. That was held within 14 days of admission.

DR. MAXWELL: Within 14 days.

A. Yeah. 11:05

DR. MAXWELL: Regardless of whether it was under Mental Health Order or voluntary?

A. Absolutely, yeah. Yeah.

DR. MAXWELL: And then at a minimum of six weeks after that there'd be a progress review. 11:06

A. Yeah.

DR. MAXWELL: Which I was informed about and I could attend, but if there wasn't going to be major changes I might just be updated after the meeting?

A. Yeah, yeah. 11:06

DR. MAXWELL: Okay. Thank you.

A. No, sorry. If there was a meeting you'd have been invited to it.

DR. MAXWELL: Yes.

A. Sometimes there may, it may be indicated that there wasn't a need for a meeting at that stage in the patient's journey. 11:06

DR. MAXWELL: There's no information to discuss.

A. You know, there was no new information or no progress

had been made.

DR. MAXWELL: But I would have been told that?

A. Oh, yeah, yeah. Yeah.

DR. MAXWELL: "We don't think there's any new information so we're not going to hold this progress meeting, but we will review it again in six weeks." 11:06

A. Yeah. Yeah. And, again, that would be fed back after weekly, you know. It wasn't just having sort of a vacuum of six weeks with no information.

DR. MAXWELL: And this was on Cranfield. 11:06

A. Yeah, yeah.

DR. MAXWELL: So this wasn't necessarily happening on the other wards, because they weren't admission wards?

A. Ehm, I'm not sure.

DR. MAXWELL: Okay. 11:06

A. I don't know that.

55 Q. MS. BERGIN: If we could look at paragraph 38, please? And between paragraphs 38 and 40 you refer to audits. Paragraph 38 you say:

11:07

"As a charge nurse, my role in examining the effectiveness of a care plan would have been to conduct care plan audits on the individual care plans."

You go down further -- further down the paragraph you then continue to say: 11:07

"I also ensure that all healthcare workers had read only access and were allowed time to read patient care

plans, keeping up-to-date."

And you say that you ensured records were also available for audit by RQIA.

Paragraph 39 you say:

"In my later years at MAH I conducted the audits."

I presume you're referring to the same period of time there? 11:07

A. Yeah, that would been --

56 Q. Yes. Between --

A. -- 2001, as a charge nurse. Yeah. Yeah.

57 Q. 2001 and 2017. 11:07

A. Yeah. Yeah.

58 Q. And then you say:

"Once the audit was completed, I went through the feedback with the named nurse of the particular patient and dealt with anything that needed to be addressed or improved." 11:08

You then say:

"There was also an external audit team, Equate, who conducted twice yearly audits of care plans." 11:08

A. Ehm...

59 Q. And at paragraph 40 you then say "I think" --

CHAIRPERSON: Sorry, did you want to correct something?

A. Just that it should have been internal, not external.

60 Q. Apologies. An internal audit team?

A. Yeah. 11:08

DR. MAXWELL: Internal to where, MAH?

A. To the hospital. Not -- yes, MAH.

DR. MAXWELL: So it wasn't from the Corporate Governance Team.

A. No, no. It would have been professional staff from -- was a multidisciplinary approach. 11:08

DR. MAXWELL: So it was like a peer review?

A. Yeah.

DR. MAXWELL: Rather than a separate team that only did audits? 11:08

A. Yeah. No, it would have been people that would have been deployed for a certain time to go and do audits like, you know, and it happened -- I think it was every six months.

DR. MAXWELL: And did they look at every patient or did they look at a sample? 11:08

A. No, there were just a sample like.

DR. MAXWELL: So potentially my care plan might not ever have been examined, if I was unlucky?

A. Possible. Yeah. 11:09

DR. MAXWELL: Yes.

A. And, again, some auditors chose the care plans they wanted to, very similar to when RQIA, someone says "Bring me six care plans", other auditors would have

said "Can I see the care plan of A, B, C and D?" So...

DR. MAXWELL: Okay.

61 Q. MS. BERGIN: You continue, and I'm going to ask you about the audits now.

A. Yeah. 11:09

62 Q. But you continue then, just to finish the point at paragraph 40, to say that you think that patient care improved as a result of these audits because there was more of an oversight of documentation?

A. Yeah. 11:09

63 Q. So we'll come to the Equate audit team in a moment, but in terms of the care plan audits that you carried out, how often were they carried out?

A. We carried out four a month. So I carried out two, and then the deputy, Deputy Ward Sister carried out two as well. 11:10

64 Q. And just as Dr. Maxwell has asked, would it be the case that all patients on the wards you were on would have had their care plans audited?

A. Depending on the length of their stay within the hospital. Ehm, so we obviously didn't take the same patients all the time like, you know, we worked through. We had - myself and the deputy had a plan and a rota and knew which care plans we were going to audit next. But the patient could have been discharged before that audit ever took place. So in that scenario their care plan wouldn't have been audited. 11:10

DR. MAXWELL: So there's you and the deputy auditing?

A. Yeah.

DR. MAXWELL: And there's the Equate team. So there's two different teams of people who are auditing?

A. Equate was historic. It stopped. Ehm, I'm not sure exactly the year? Ehm, it would have been some time between, ehm, maybe about 2010, 2012. 11:10

DR. MAXWELL: Okay. So when that stopped you decided to do - you and your deputy did your own?

A. Well, I don't think it was a conscious decision that we decided to do it, like I think it was good practice from throughout the site like, you know. 11:11

DR. MAXWELL: Yeah.

A. It wasn't just something that -- and I suppose it was, a lot of it was in preparation for RQIA audits too, because you just didn't -- if you had of left it so that there was only an audit once a year, then we 11:11 wouldn't have picked up if there was issues with care planning or, you know, and...

DR. MAXWELL: And did those audits, either the Equate or the ones you did, did they get reported through to the Director at clinical governance meetings, or did 11:11 they just stay with you as the Ward Manager?

A. The care plan audit stayed with me. I think Equate audits went through -- reports were generated through their system, and it certainly went to Service Manager level, the Equate audits. 11:12

CHAIRPERSON: And did it happen, during the course of your audits, that you occasionally came across a care plan that hadn't been reviewed as it ought to have been?

A. Yeah.

CHAIRPERSON: Where would you take that to, if you felt that something hadn't been updated properly?

A. Ehm, well, after every feedback -- or, sorry, after every audit, feedback was given both verbally and it was recorded as well with that named nurse. 11:12

CHAIRPERSON: To the named nurse of that patient?

A. Yeah. And then there would have been an opportunity to re-audit that. You know, we would have given -- we would have developed an action plan for that named nurse. You know, it may well have been that, you know circumstances, why it wasn't at the standard, like it could have been maybe there was absence or other duties were presenting. 11:12

CHAIRPERSON: Yeah. 11:12

A. So we had to ensure that the named nursed had the time then to devote to developing a person-centred care plan.

CHAIRPERSON: And can I just ask this, because this sounds like, you know, good practice and what ought to be happening. As a charge nurse, did you have meetings between other charge nurses on other wards to ensure that practice was consistent across the hospital? 11:13

A. Yeah, we had -- there was two sets of meetings. My line manager had a weekly unit meeting, so that would have included the charge nurses, Ward Sisters from the core hospital, from Cranfield and Six Mile. Then as well as that there was a monthly Service Manager meeting, which included all the Ward Sisters and charge 11:13

nurses from the site.

CHAIRPERSON: But what would those meetings cover? Would they cover details such as how often audits are done?

A. Yeah, yeah. It would have, would have talked about, you know, as you said, about good practice. 11:14

CHAIRPERSON: Right. So there should have been consistency across the wards?

A. Should have been, yes.

CHAIRPERSON: Yeah. Thank you. 11:14

65 Q. MS. BERGIN: Just two final points to clarify with the audits and then I think it might be an appropriate time to take a break?

CHAIRPERSON: Yes.

66 Q. MS. BERGIN: The first is, in terms of the chronology of audits, is it the case that there was a period of time when you were doing audits when the Equate audits were also happening, or did one follow the other? 11:14

A. No, they didn't run concurrently, no. Yeah.

67 Q. And apart from your audits that you were doing, was there any other form of audits? You've referred to RQIA. Was there any other form of audit? 11:14

A. Not that I'm aware of.

DR. MAXWELL: Sorry, can I just ask? There were -- we've heard about medical audit. Was there not a clinical audit programme? And I understand you're talking about the nursing care plan. 11:14

A. Yeah, yeah.

DR. MAXWELL: Were there other audits that might fall

under clinical or medical audit?

A. Yeah, you know, when you do mention it, there would have been audits of the, specifically of the clinical file and the medication Kardexes. But, again, I don't remember anything ever being shared about that with us at our level. 11:15

DR. MAXWELL: Thank you.

MS. BERGIN: And finally then at paragraph 40 you say that sometimes what you saw on the ground as good practice was not always reflected in the care plans. 11:15

"Nursing staff did not always have time to record everything or highlight the good practice. Daily recording of notes would be factually accurate, however there wasn't always time to record all of the steps that nurses went through to achieve positive outcomes." 11:15

This may seem like an obvious question, but what is it that you expected to see when you were going through the audits in terms of care plans? 11:15

A. Ehm, well the main thing would have been that it was person-centred and that the care plan -- I could have lifted a care plan and it would have documented to me exactly what that patient's needs were, and how I should respond as a care staff, and what worked best for that patient. And the example that I referred to within the witness statement is about -- it was an individual who required his personal hygiene, to be assisted with his personal hygiene, but he was quite 11:16

agitated and distressed at that time, and the nurse, and several nurses, and they changed over between it, but they communicated with the individual for up to an hour, you know, and offering different things and different approaches, and at the end of the day the patient then willingly went and had his hygiene assisted. But the care plan didn't document that. It more or less said that the patient was distressed, initially refused to be assisted with his hygiene. Staff spoke to him, and an hour later he agreed to it. But there was so much more that the nursing staff did within that period, you know, and that was just something that we reflected on and used that as learning for our nursing staff, to highlight the good practice that they actually were, you know implementing, and then recording. Whereas I got nothing from -- it just I happened to be present on the ward that day when that incident happened, and it just wasn't a reflection of the level of care that was given to that patient. 11:16 11:17 11:17 11:17

MS. BERGIN: Chair, I wonder if it's an appropriate time?

CHAIRPERSON: Yes. Just before we break, can I do a bit of housekeeping, which I should have done earlier in the week and I'm afraid it slipped my mind, I'm sorry. Just to let everybody know, we are not sitting in the afternoon of Thursday the 26th of September, and we are not sitting the following week. We will be back on Tuesday, 8th October. So there will be a break 11:18

between the afternoon of the 26th, Thursday the 26th, although we'll sit that morning. We're not sitting until 10:00 o'clock on Tuesday the 8th. And I'm sorry, I should have told everybody that earlier this week. Okay. We'll take a 15-minute break. You'll be looked after, I hope. I don't know if you've got anybody with you, but just don't talk about your evidence. 11:18

A. Yes, I have. Yeah, yeah.

CHAIRPERSON: Fine. 15 minutes. Thank you very much. 11:18

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you. Thank you. Okay.

68 Q. MS. BERGIN: Thank you. If we could pick up then at paragraph 43, please? And we're moving on now to the topics of restrictive practices, seclusion, deprivation of liberty, which you refer to. So moving between paragraphs 43 to 46, here, you, as I've said, refer to deprivation of liberty and the use of restrictive practices, including how the use of these practices was recorded and reviewed at MDT meetings. The use of physical restraint when a patient was aggressive being the only option and last resort after pursuing proactive strategies, and how this use was recorded, and you say that: 11:36 11:36 11:36

"In each case when a restrictive practice was used, it was reviewed at the next MDT or earlier, if necessary."

And at paragraph 44 you say:

"On Cranfield Men's Ward, you ensured that there were no blanket restrictive practices implemented that affected every patient." 11:37

At paragraph 46 you say that:

"Decisions around restraint and seclusion were taken at MDT meetings and reviewed at those meetings." 11:37

And you say that they were also flagged for review if it was the first time that they had been used with a patient or there was an unusual use, and that families were informed as soon as possible afterwards. 11:37

At paragraph 49 you outline some examples of restrictive practices that you recall during your time at Muckamore, including: 11:37

"Restricting patient movement in terms of locked doors, seclusion, physical restraint, alarming patient bedroom doors when there was an identified risk, one-to-one supervision." 11:37

And you say that:

"Whilst this could provide therapeutic interventions

and opportunities, there was an underlying restriction to these practices."

At paragraph 50 you say that Movilla A, Fintona North and Cranfield Men's Ward were all locked wards with all external doors locked and they required a key or access control card to enter, and you say that Movilla A and Fintona North had locked day rooms which were never left unsupervised. 11:38

Then continuing on to paragraph 51 you say that: 11:38

"The alarming of patient doors was only used on Cranfield Ward. This was a multidisciplinary decision and was recorded as a restrictive practice and reviewed weekly at MDT meetings. It would have been used rarely as opposed to a regular intervention. This was used as a least restrictive practice due to one-to-one supervision being very intrusive." 11:38

You say that on Fintona South Ward there was no seclusion, it didn't have a seclusion facility. And then you say at paragraph 52: 11:39

"All use of PRN medication, restraint and seclusion, was recorded in individual care plans, audit forms, ward reports, and discussed weekly at MDT meetings or more often, as necessary, with medical staff or the consultant psychiatrist." 11:39

So with that in mind, was it always the case from when you began at Muckamore in 1989 that the use of restrictive practices were reviewed at MDT or, when, during your time at Muckamore, did that feature? 11:39

A. Restrictive practices, probably the terminology "restrictive practice" wasn't used then, and I'm not too sure when the terminology was used. But the practices which are outlined as restrictive would have been discussed and reviewed at the multidisciplinary, 11:40 the weekly multidisciplinary team meeting. So nursing staff would have correlated any incidents requiring seclusion, physical intervention, use of "as required medication", and that would have been discussed then with the MDT on a weekly basis. 11:40

69 Q. And just to stop you there. Would that have been, to the best of your recollection, your experience throughout your time as a Staff Nurse beginning in 1989, then as a charge nurse, and thereafter in terms of day services? 11:40

A. Absolutely, it would. I suppose the difference would be, would be the documentation, you know, and towards the end of my employment, probably the last, probably from 2015/16 onwards, and it might be a bit earlier than that, there would have been documentation where 11:41 the restrictive practice was actually recorded on, and when the review date was and, you know, who was involved in that decision making initially and who was then present when it was reviewed.

70 Q. When you refer, and I've already read this aloud, to ensuring that there were no blanket restrictive practices affecting every patient, can you clarify what you mean by that?

A. Well, restrictive practice should be the least restrictive, and there shouldn't be -- you know the guidance instructs us that there is, there shouldn't be a blanket restriction which covers an environment as opposed to an individual being cared there. Maybe an example is within Cranfield, whilst there was a locked door, we would have had patients who could access the grounds on their own, was referred to as "unsupervised time", and that may have been just to go for a walk on the grounds. It may be some individuals had -- were able to go down into the local town, use public transport up and down. So it was assessed on admission or as soon after and as their admission progressed like. So whilst they didn't have a key to the door, you know, they were able to gain time out whenever they chose like. 11:41 11:42 11:42 11:42

71 Q. So in relation to Cranfield that you've just referred to, Cranfield, I think if I'm correct, opened around 2006?

A. Yeah, yeah.

72 Q. And you've said that that was one place, well in fact the only place where the alarmed doors were used? 11:42

A. Yeah.

73 Q. So is it correct that that was a new type of restrictive practice that was being used?

A. Yeah. Ehm, I suppose in the older environment there wasn't -- patients didn't have individual bedrooms, there would have been some patients did have, but there was no facility to lock the doors. Within the Cranfield bedrooms there was a suite of keys, so nursing staff held like a master key which covered every door. Patients on admission then were assessed on whether they were able to carry their own key or whether they wanted their own key, and each bedroom door was individual then, so they could access in and out of their bedroom as they chose. 11:43 11:43

The alarm system then was an extra facility where it could have been turned on, the alarm activated, and not a screaming alarm like, you know, it was a beep on a handheld receiver that such and such a bedroom door was open. But, again, it was only through an MDT discussion and if there was a risk presented. 11:43

So say there was two patients that there was maybe a protection plan in place, and they weren't allowed to meet unsupervised, one of the practices may have been to alarm the patient's bedroom door so that he couldn't get gain access, say if he had of been a perpetrator in a safeguarding incident. 11:43 11:44

74 Q. In terms of patients having access outside more generally beyond the grounds of Muckamore, but also specifically what I'm focusing on here is, in terms of a practice where patients might be prevented from going

out to the garden that might be attached to a ward, or be in the garden and be prevented from coming back in via locked doors, is that something that was considered to be seclusion?

A. Ehm, it would have been seen as seclusion if it had have been a practice that was used, but certainly, you know, within Cranfield that wasn't, you know, the -- we were able to, the door into, and it was a secure garden in that it had a secure fence around it, ehm, the door to that area was open, it could be left open like, and it was left open. Certainly between daylight hours. It was different at night-time like, you know. I suppose there was less staff resource like, but a patient would have had to ask to have access out to it after that. 11:44 11:45 11:45

75 Q. In terms then of other patient movements around or outside of the ward, what about the use of, for example, a low stimulus room? Would that be seen as a form of seclusion?

A. It wouldn't be seen as a form of seclusion, ehm, but it would be a documented procedure and processed within the patient's care plan if that was used. Cranfield itself didn't have a low - Cranfield Men's Ward didn't have a low stimuli room or a seclusion room, but occasionally patients were facilitated with the use within the PICU for the seclusion room there. 11:45 11:45

DR. MAXWELL: And if you're using low stimulus...

A. Yeah.

DR. MAXWELL: So even if you're using the seclusion

room, was that always at the patient request, or could a nurse decide this patient needs some low stimulus time?

A. Ehm, there was times that nurses would have encouraged it, if the patient was getting upset. 11:46

DR. MAXWELL: So if the nurse decided they needed some low stimulus time, would that be a deprivation of liberty if it wasn't the patient's choice?

A. Yeah.

DR. MAXWELL: It would? 11:46

A. Yeah, yeah. Yeah, I believe so.

DR. MAXWELL: So it should have been recorded as a seclusion?

A. Not as a seclusion. It would have been recorded as a restrictive practice, but not a seclusion. 11:46

DR. MAXWELL: The Inquiry has heard that there were quite detailed approach as to how seclusion was recorded and how often they had to be reviewed.

A. Yeah.

DR. MAXWELL: Did those rules apply to low stimulus as well? 11:46

A. Ehm, they didn't. The seclusion policy as such didn't, didn't apply to low stimulus.

DR. MAXWELL: So if I had been working on the ward and I had felt a patient was becoming agitated and would benefit from some low stimulus time. 11:47

A. Yeah.

DR. MAXWELL: Would I just record it in the nursing progress notes?

A. No, it would be seen as a restrictive practice. So there would have been -- a seclusion care plan wouldn't have been implemented or used, but it would have been recorded as a restrictive practice and it would have been documented on the pro forma that we use for, and then that would have been discussed at MDT.

DR. MAXWELL: So there is a pro forma for any restrictive practice. 11:47

A. Yes.

DR. MAXWELL: Whether it's low stimulus, physical intervention, or seclusion. 11:47

A. Yeah. Yeah.

DR. MAXWELL: And I would have had to fill in that form, but wouldn't be following the seclusion policy?

A. Yeah. 11:47

DR. MAXWELL: So all --

A. And it would have been discussed at the next MDT meeting.

DR. MAXWELL: Okay. If a patient had asked for low stimulus time, would I have had to record that? 11:48 Because that's not restrictive if the patient has asked for it.

A. No, that wouldn't -- it wouldn't be. It would be seen that that would be something therapeutic that the patient had asked for. We didn't, within Cranfield Men's Ward, we didn't use it that often because there was loads of other spaces within the environment that the patient could have used like, you know, whether it had have been their own bedroom. There's was a quiet 11:48

room, there was a small activity room which -- so it was rare that...

DR. MAXWELL: And if, as a patient, I decided I just needed some peace and quiet, and I had gone into my bedroom and locked the door myself, again that's my choice. 11:48

A. Yeah.

DR. MAXWELL: Would that have been recorded as anything?

A. No. 11:48

DR. MAXWELL: Because that's my choice.

A. Yeah. Yeah. And like patients would -- and I suppose that was the beauty of Cranfield compared to the older admission wards, that patients could do that, because they had access. 11:49

DR. MAXWELL: And if I, as a member of staff, felt that this patient needed some low stimulus, but I hadn't - but they hadn't asked for it, could the healthcare assistants make that decision?

A. Ehm, they would -- they could make the decision, but the nurse would be, the nurse in charge would be informed straight away that this is what -- 11:49

DR. MAXWELL: So they would do it first and then inform the registered nurse afterwards, rather than suggest it to the registered nurse? 11:49

A. Ehm, I couldn't say exclusively on that.

DR. MAXWELL: There wasn't a clear policy?

A. No.

DR. MAXWELL: So potentially healthcare assistants

could be making this decision without reference to a registered nurse.

A. They could be making this decision but informing straight away the decision was made like.

DR. MAXWELL: And just -- 11:50

A. And then I suppose within Cranfield Men's Ward, like no patient was taken to the low stimulus room without a Registrant knowing about it, because it was taking a patient out of the environment, and that certainly wasn't allowed. 11:50

DR. MAXWELL: Okay.

A. What actually happened within the PIC Unit, where it was beside each other, I don't know.

DR. MAXWELL: And so could a healthcare assistant decide to use a physical restraint without referring to 11:50 a registered nurse?

A. You can't use physical restraint yourself.

DR. MAXWELL: Or could two healthcare assistants?

A. If there was an inherent risk at that time to somebody else, they would have done that, activated their alarm, 11:50 and then registrants would have been there. The environment itself allows to within seconds that there is support there.

DR. MAXWELL: So if you're going to use a physical restraint you have to activate your personal alarm? 11:51

A. Well, it would be the first thing that you would do.

DR. MAXWELL: But is that a requirement?

A. I think it is within the -- I can't remember, you know specifically, but I would imagine it's in the policy.

DR. MAXWELL: Yeah, yeah. Okay. And given that these situations arise very quickly, if restrictive practices hadn't been discussed at the MDT, so there wasn't a restrictive practice plan, could staff in an emergency use that even if there wasn't a plan? 11:51

A. Yes.

DR. MAXWELL: They could?

A. They could. And then that would have been -- that's when I talk about flagged for the first time. So we wouldn't blanket, have blanket restrictive practices 11:51 for every patient saying everybody needs a seclusion, because that would be wrong. Ehm, so it would only be if a need arose. So it wouldn't have been planned in advance, as such like, unless the patient came in with a history of violent behaviour and to that level and 11:51 possibly warranted it.

76 Q. MS. BERGIN: I appreciate you've already indicated in response to Dr. Maxwell that you can't recall exact policies in terms of, you know, what to do when you're about to initiate a particular practice. 11:52

A. Yeah.

77 Q. But thinking to your time at Muckamore, you were in perhaps a somewhat unique position of being there for a considerably long period of time from 1989 to 2020?

A. Yeah. 11:52

78 Q. And throughout that time would it be fair to say that there were changes in the types of restrictive practices that were used at Muckamore?

A. Yeah. For example, when I first started there was no,

ehm, there was no training on physical restraint, that only came about some time in the early '90s, from recollection. Whilst patients would have had to be restrained, the policy sort of designated that you held on to a limb, whereas there wasn't any specific techniques. But as time developed and staff were trained in, I think it was called at the beginning it was care and responsibility training, and then that developed into the MAPA model that is probably still in existence, I would imagine. 11:53

79 Q. And as changes in best practice, and then presumably Trust policies may have occurred relation to MAPA, how were those changes in what you were meant to do in those situations communicated to you and your team?

A. Yeah. Well, I suppose like it was - there'd would have been an oversight at the senior manager's meeting, the Service Manager's meeting, and that would probably have been the first port of call that we'd have heard that, you know, there is new training coming onboard, there is a different approach, and then staff would have all received their training. 11:53

80 Q. Can you give us some idea of, and I appreciate it's a lengthy career at Muckamore, but can you give us some idea of how frequently you would have been having updates or training in relation to MAPA? 11:54

A. Well, MAPA is an annual training. Initially -- I'm not sure whether it was, the timescales like, but certainly when I retired it was a 12 month, 12 monthly update. And I suppose the management of aggression like, it

wasn't specifically just about restraint, it was all the de-escalation and the communication like, you know, and that was -- and over the course, the course, the training course, there was more time spent on de-escalation of behaviours than there actually was on the physical part of it. But unfortunately people view MAPA as physical restraint, but it's much more than that.

81 Q. And throughout your time at Muckamore, if you're able to say, can you comment on whether, in light of MAPA and de-escalation focus that you've touched on, it was your impression that the use of restrictive practices, or in particular the use of physical restraint, was something that stayed the same, increased, decreased?

A. No, I believe it decreased, you know, and because we were given more resource and we did have more sort of tools that we could use in terms of de-escalation and communication, and staff were trained as opposed to learning from one another what worked best, you know, you had a specific model to follow. And care planning played a very important part in that process too, where it was individualised as opposed to just a care plan for aggression, where this was tailored to the individual.

82 Q. At paragraph 47 and 48 then, moving onto the topic of PRN very briefly, the Inquiry has heard evidence about patients being overmedicated, to the point that they don't know what's happening around them.

A. Yeah.

83 Q. And at paragraph 47 and 48 you say that:

"PRN medication was prescribed by a doctor and this specified the medication, dosage, route, time frequency and most importantly the reasons why a particular medication should be administered." 11:56

You say:

"The most recent prescription cards used before you moved out of the wards only had a set number of recording boxes once PRN medication was administered, resulting in a review of the medication by a medical officer and a decision taken to prescribe again, reduce or increase dose, or discontinue the medication." 11:56 11:57

And you say that:

"Nurses only administered what medical staff prescribed and were required to stick rigidly to the prescription." 11:57

Now first of all, when you refer to the most recent prescription cards used, can you tell us a bit about why they were introduced and what the reason for that was? 11:57

A. Yeah. Ehm, it was, Belfast -- well, I think it was initially Belfast Trust initiative. Prior to that each facility were working off different type of

prescription and recording card, so it was bringing us in line with what was happening in acute services. I think the only difference was within the Kardex that was introduced in the hospital there was an eight week recording of general medication, you know regular 11:57
prescribed medication, whereas I think in the acute sector it was a two week prescription card. But within that there was various sections, and one covered PRN - as required medication, where the medication was recorded and then below it was the recording boxes for 11:58
that medication, and it only gave a certain amount. So once that prescription -- there was nowhere to record, a nurse couldn't administer another dose, and what that was brought in for was so that the medication was reviewed in a timely fashion. Historically with the 11:58
old prescription cards it was a 52 day review, whereas this reduced it down to their full medication card being reviewed every 42 days.

84 Q. But your understanding is that that was a broader Belfast Trust change rather than -- 11:58

A. Yeah, yeah.

85 Q. It wasn't specific to Muckamore?

A. No, it wasn't specific in Muckamore, but it was something that was brought in, which actually there was an inherent benefit to it like. So that didn't, you 11:59
know, if you think the medication could be given every six hours, so that would be four doses within a 24-hour period. If you only had six boxes to record a medication, even over a weekend, you couldn't do it

without bringing a medical officer in to rewrite that particular prescription. So there was safeguards built into that new system and that new Kardex.

86 Q. At paragraph 52 then, you say that:

"The use of PRN restraint and seclusion was recorded in care plans, audit forms, ward reports, and discussed weekly at MDT meetings." 11:59

And you go to say that: 11:59

"There was shared learning from other wards via monthly charge nurse and Ward Sister meetings, Chaired by the Service Manager and attended by Senior Nurse Manager."

And in the few years before you retired the Heads of Department also attended these meetings, to include safeguarding, social work, psychology and psychiatry? 12:00

A. Yes.

87 Q. Now the Inquiry has heard from other witnesses that they didn't feel that learning was shared in other areas at Muckamore. For example, in relation to the Ennis Report? 12:00

A. Yeah.

88 Q. So what was your impression about the sharing of learning across wards? 12:00

A. I think it was -- the service managers' meeting was a useful environment, it was particularly good to hear when another ward had received an RQIA audit, for

example, and the learning from that was shared, which did improve practice, you know, and if there was specifics that were identified in other wards, you ensured that, you know, that that practice wasn't happening, and if there was a recommendation, for example like, you know you were able to go and address that even before the audit, so it improved patient care.

In terms of the Ennis Report, I wouldn't have been -- I was aware that there was allegations made, but I wasn't aware of what they were or, you know, there certainly wasn't any shared learning from my recollection from that investigation. We were asked as senior staff on the site to consider undertaking a monitoring role within Ennis, and it was a voluntary role and paid outside of your regular employment, unless there was nobody available to do it. So on one occasion I was asked for a part of a shift to go in and be the monitor for those, I think it was three and a half hours. That was the only time I done it, but I didn't feel it was appropriate that a male staff was in monitoring in a female environment, because there was areas of the ward that you weren't able to, and you shouldn't have been going into, so you shouldn't have been going into patient bathrooms. And it was similar to my time spent in Fintona. And I suppose we seen that as good practice then that male staff didn't enter, you know, female patient's private areas. So I only done it the

once and then raised that I wasn't comfortable, and that was accepted and I wasn't asked to do the monitoring again.

PROFESSOR MURPHY: But given what you've said about the service managers' meetings. 12:02

A. Yeah.

PROFESSOR MURPHY: These monthly meetings where you shared practice across wards.

A. Yeah.

PROFESSOR MURPHY: I'm astonished that Ennis didn't get discussed? Did none of you -- you must have known there was something going on there, otherwise you wouldn't have been asked to do this monitoring. 12:03

A. Yes, we were because -- yeah.

PROFESSOR MURPHY: Did nobody say "But, you know, what happened in Ennis? What do we need to learn from it?". 12:03

A. I don't have any recollection of it. I can't answer, you know, any more than that. You know, certainly we, you know, as time went on you were made, you were more aware, but I don't know whether that was from formal meetings or whether it was hearsay, you know. So I can't say that it was discussed. 12:03

PROFESSOR MURPHY: So when you went to monitor on this one occasion, did you know what you were monitoring for? 12:03

A. Yeah, we had -- there was a meeting with -- and I need a cipher number for a particular staff.

DR. MAXWELL: I think you can say her name.

A. No, it's not on that. Do you want me to write it down?

CHAIRPERSON: Do you want to write it down and show it to counsel?

A. Yeah. It was -- we had a meeting with Mrs. Mannion and she brought all the charge nurses and Ward Sisters together specifically, had said that there was an investigation. I can't remember the terminology, whether she used "suspected" or "abuse", ehm, there was certainly allegations of that, and then had instructed us what our role would be in monitoring. At that stage it was said that it would be voluntary, you know, unless people didn't come forward like. So quite a lot of the senior staff put themselves forward on a rota and were paid then at whatever rate like for extra.

PROFESSOR MURPHY: So was your understanding of the task then that you were monitoring for further abuse or that you were monitoring for poor practice?

A. Yeah, poor practice. And there was -- again there was a pro forma that we had to complete, and it highlighted any - any concerns that you had. It named on it who the nurse in charge was of the ward, the names of the staff that were on duty on that shift, and then what areas of the ward you monitored. And any, both poor practice or good practice that you witnessed during the time of monitoring, and I believe then that went to the Service Manager and any information was correlated. But we weren't fed back on what other monitors had seen. But I suppose because I opted out of it in terms of it wasn't something I was comfortable with, you know maybe I buried my head in the sand a bit and didn't

look towards it because it wasn't something that came into my day-to-day working.

CHAIRPERSON: But if there was an action plan arising out of Ennis, you never saw it?

A. I've no recollection of that, of seeing one. 12:06

CHAIRPERSON: And there was no sort of group discussion that you can remember?

A. I can't remember anything specific about it.

CHAIRPERSON: Thank you.

89 Q. MS. BERGIN: If we could look at paragraph 53, please. 12:06

A. Yeah.

90 Q. And here you say that you satisfied yourself that unregistered staff were doing their jobs properly, healthcare workers or nursing assistants, and you refer to their induction to the wards, mandatory and 12:07 additional training, including safeguarding, MAPA and Makaton, and that they had full access to patient records. You then say:

"There was always a registered nurse in charge on every 12:07 shift."

When you say a "registered nurse" are you referring to a Staff Nurse or charge nurse there?

A. Ehm, either. It could be a Staff Nurse, Deputy Ward 12:07 Sister. So it would be an Registrant like, so from a Band 5 upwards.

91 Q. And -- apologies?

A. Sorry, no, just Band 5, 6 or 7.

92 Q. And when you say that you satisfied yourself that unregistered staff were doing their roles properly, how did you actually supervise them?

A. Ehm, I was -- certainly during my time in all the wards like I wasn't an office based charge nurse. Ehm, I spent quite a lot of my time at the, you know if I was doing administrative work I took it out into the staff base area rather than sit behind an office door. So I was observing all the time that I was, or the majority of time. Ehm, Cranfield was also set up that the ward office had a full glazed panel so you could see out. So you weren't -- I think some of the other wards was maybe the office wasn't in the older hospital, the office was maybe at the end of a corridor, whereas we had full view and full sight into the patient area. It was also an area that sound travelled, so you would hear anything that was going on within the ward as well. 12:07 12:08 12:08

93 Q. So, I think you may have already answered this in part, but so how was it that you ensured that those types of staff weren't exceeding their authority? For example, when it came to matters of restrictive practices. 12:08

A. Yeah. Again, from observation. We also had patient experience audits as well, ehm, where we sat down, like where named nurses, or myself and the deputy would have sat down with a patient, we all took several patients and went through on a regular basis then an audit, but I suppose on their care in general. But there would have been opportunity within that for them to raise any 12:09

concerns if they had, particularly against well any member of staff like really?

94 Q. And you had said in your evidence there that you weren't really an office based charge nurse, you were out on the ward more? 12:09

A. Yeah.

95 Q. What about your colleagues in similar positions?

A. Ehm, certainly within -- I suppose I can only talk about experience, you know my experience, and it was something I think I referred earlier on in my evidence, 12:10 about the Ward Sisters and the charge nurses that I worked under when I was a Staff Nurse were very hands-on, and that's where I got the ethos of, I suppose, admired those qualities in those individuals, you know. So I don't know if that answers it or... 12:10

DR. MAXWELL: Can I just ask you, so you were out observing what was happening on the ward, so you had a good understanding of how people were working?

A. Yeah.

DR. MAXWELL: Did you ever have occasion to speak to 12:10 any of the healthcare assistants to say " What you're doing is inappropriate"?

A. Ehm, I don't, I don't recall any specifics regarding that.

DR. MAXWELL: But you never saw anything that you 12:10 didn't think was best practice that you thought you needed to speak to somebody?

A. I certainly didn't observe any poor practice. And, again, I can't think of anything specific, you know,

because there was nothing, nothing untoward that I observed, but maybe thinking about a better way of approaching a situation or talking to a patient.

DR. MAXWELL: But nothing you think was poor practice?

A. No, but maybe where patients, especially when staff were on one-to-one supervision, ehm, I always seen it as an opportunity to engage with a patient, if the patient wanted you to engage with them. So rather than sit about in a day space, or in a day room, we would have encouraged sort of the healthcare workers to take, you know the individual, and go out for a walk. So some staff probably would have needed more encouragement to do that, as opposed to others would have been more proactive. 12:11 12:11

DR. MAXWELL: Can I just ask about that, because we've heard that one-to-one supervision should only be done for two hours at a time and then a member of staff should have break because it's quite intense. 12:11

A. Yeah, I think it's -- there's certainly patients that we would have followed that two hourly thing with. But then there were other patients that I suppose their reason for having a level of supervision played into it. Like it could have been to do their vulnerability and the risk that other patients maybe posed to them. So if the patient themselves weren't challenging, but they required a staff to keep them safe, I think the two hour rule wasn't something that we 100% used. And it was down to individual staff as well if they were comfortable for that. Now we had staff that would have 12:12 12:12

taken a patient out for several hours at a time, so you couldn't possibly have rotated, do you know. But they were maybe out at a sporting event, or a community event or whatever.

CHAIRPERSON: Could I just ask on a related topic perhaps, in relation to staff behaviour? On the wards where you worked, was there a staff table for lunch? 12:13

A. No, within Movilla there was no staff facilities on the ward, so the only place that staff could eat was in the day area, which was something that we weren't comfortable with, but there wasn't any alternatives. So when we were planning the new units and the new hospital, we ensured that there was a staff facility within it, and that's where we use. Now staff might have had a cup of tea in the morning, like before patients you know done the handover, and maybe had a cup of tea at the staff base, but they certainly didn't take meals there. We went off the ward for our breaks. 12:13

CHAIRPERSON: And going back to Movilla, just imagine there are patients who are on the ward, would it have been appropriate at any stage for all the staff to sit together? 12:14

A. It wouldn't have been all the staff. It might have been -- so we would have split tea breaks, but some staff would have sat on the ward and would have been there still supervising and observing patients. 12:14

CHAIRPERSON: And obviously staff are perfectly entitled to take breaks, and if they happen to have breaks together that presumably is okay?

A. Yeah. Yeah. But there was just, there was nowhere else where you could have taken your lunch, you know, and it was something, you know, it was a practice that we didn't like or we didn't want, so when we had the opportunity to change things, that's what fed into the new hospital.

DR. MAXWELL: Can I just ask about Cranfield? So you're saying that there was a staff facility, there was somewhere for staff to go and have their meals? But at times when you were short-staffed, if there weren't any staff to come and relieve the ward, what would happen then? Because if you're understaffed and people need to go for their break, the staffing then becomes unsafe? 12:14 12:15

A. Yeah. We ensured that that was, you know, it could be a challenging environment to work in, and it was important that staff got, even if it was their 10, 15 minutes, 30 minutes away, they needed that. So it was a practice that we insisted that happened. But it wasn't -- 12:15

DR. MAXWELL: How did you do it if there weren't enough staff?

A. We staggered the breaks like and we took them over a longer period. So we started breaks earlier and ran later. 12:15

DR. MAXWELL: Did you ever bring in staff from other wards to cover?

A. Occasionally. But sometimes the day care staff were used for that. Some day care staff actually stayed on

for an hour to do overtime and then would have came in to certain wards that were struggling like to get the staff breaks.

DR. MAXWELL: So in your opinion there's absolutely no reason why staff would have had meals on the ward? 12:16

A. Absolutely not, no. Not within Cranfield like.

DR. MAXWELL: On Cranfield.

96 Q. MS. BERGIN: Just in relation to the staff at lunches or breaks. One of the complaints that some members of staff had made was that there were small cliques of 12:16 staff in terms of the ward culture, and we'll come to that in a moment.

A. Ah-ha.

97 Q. In other words they were, they felt excluded by the staff on the ward, and that contributed to the culture 12:16 on the ward when they were working?

A. Okay.

98 Q. Can you tell us anything about that?

A. Certainly not something that, a practice that I would have had within any of the wards that I managed. It 12:16 was -- every member of staff was as valuable as the other. Actually I would have made a point of bringing new staff to break with me when they came into the ward like, whether they wanted it or not, I don't know, but I didn't send certain staff with other staff like, so I 12:17 wouldn't have been aware of that.

99 Q. And I know we're jumping around somewhat, but on the issue of culture on different wards.

A. Yeah.

100 Q. At paragraph 19 of your statement you say:

"Whilst I worked in a variety of wards..."

- and we've heard a lot about them this morning - you say: 12:17

"...I did not observe any difference in culture from one ward to the next. Staff always had the best interests of patients at the core and generally patients seemed content." 12:17

Again, along the same lines in relation to culture, is your evidence that there was no difference in culture between any of the wards? That's what you've said. 12:18

A. Yeah. Certainly any of the wards that I worked in, I didn't see a difference in culture. And I believe that stems back to the Ward Sisters and the charge nurses that were leading the teams, and what their ethos was and what their inclusion and their person-centred-ness. 12:18

101 Q. Apologies, I didn't mean to cut across you.

A. Yeah.

102 Q. What would you consider a good culture or a negative culture on a ward to be?

A. Well, good culture is harmonious, where staff and patients are working together and that there's good communication between colleagues and with patients. I suppose that there would be minimal restrictive practices, there'd be -- there wouldn't be -- and I 12:18

can't exclude episodes of aggression or violence from patients towards others, but I suppose the less observation of that would be, would relate to an environment where patients are content. I suppose negative is the opposite where there is, you know, a distance between patients and staff, that there isn't good communication, that there is increased aggression, there's more use of PRN medication. But, again, I can only speak about the environments that I worked in and then managed. 12:19

DR. MAXWELL: Can I ask you a little bit about the duty roster?

A. Yes.

DR. MAXWELL: So often staff will make requests about what shifts they want to work. 12:20

A. Yeah. Yeah.

DR. MAXWELL: And sometimes members of staff like to work with particular colleagues.

A. Yeah.

DR. MAXWELL: Rather than others. Was there an opportunity for people to request that they always worked with people they were used to working with? 12:20

A. My only example of that would have been, and it was only happening on the same shifts, would have been within - when I managed day services. There was two particular healthcare workers that always -- they ended up -- it was something I inherited when I took over, they had the same shift patterns. So they were both part-time, and instead of it being flexible where they 12:20

could work Monday, Tuesday, Wednesday, they had set days, and they both had the same set days.

DR. MAXWELL: Okay.

A. But it wasn't -- it was so that they could have their break together and, you know, they could travel together. But they didn't work in the same groups, you know. So that's the only example of that, that I can think off-hand. 12:21

DR. MAXWELL: But on the wards, I wouldn't have been able to say "Can I be rostered with my mate Flossy?" 12:21

A. No, absolutely not. It wouldn't -- there was enough to consider in trying to balance out, you know, your resource over the week, without -- you know certainly people could have requested the same days off and you wouldn't have excluded that, that wouldn't be -- but it wasn't something that -- nobody ever came and says "Can I work with such and such?". 12:21

DR. MAXWELL: And were there people who were rostered only to do nights?

A. Ehm, there was, yeah. Ehm, nights was a difficult thing to cover because of the unsocial hours. And we did, you know, those people that done nights, we brought them off on to day duty for a period of time like, you know, so that they were seeing the fuller picture. And likewise, you know, people, people doing - who were normally on day duty went and done nights. But we did try at the beginning of Cranfield to have a full rotation, but you found that staff were unhappy, that they didn't want to do nights, whereas you had 12:21 12:22

people who were more comfortable with that routine and suited their family. But as long as staff came off and done, you know, I think it was six weeks they would have came off and done periods of day duty, you know, and attended their mandatory training, we didn't have an issue with it. There was quite a few part-time staff working night duty, so it wasn't the same core of staff working every shift together on night duty, there'd have been a rotation within that as well. 12:22

103 Q. MS. BERGIN: If we could go to paragraph 59 then, please? And here you say: 12:23

"My experience throughout my career with management was one of openness and honesty. Mutual respect was evident between my managers and myself. I never experienced any negativity from my managers when faced with issues." 12:23

Did you raise issues with management and, if so, what types of issues and how were they dealt with? 12:23

A. Well, I suppose, you know in terms of, you know we've just been talking about staffing, like you know at times when maybe it felt that there wasn't enough registrants on the ward like, and raising that with a line manager in particular like, you know, and coming to some understanding, you know. And, again, as I said earlier, you know, you can't have everything you want, but if there's a bit of give and take. So, no, I certainly -- I can't fault the managers that I had in 12:23

terms of the support that they gave me, you know throughout my career like, and I'm talking, you know, from charge nurse, Ward Sister level, up to line manager, service managers.

104 Q. At, and I'm jumping around somewhat, but at paragraph 72, and here you refer to staff being assaulted by patients, and you say that they were supported, the staff, in a compassionate and respectful manner and each incident would be treated sensitively. 12:24

Was there a policy or was there guidance in terms of how to deal with these types of incidents?

A. Ehm, there would have been the policy in terms of -- I'm trying to think of the name of it - Occupational Health policy in terms of supporting a member of staff like, but that was to do with any sickness and any absence, as opposed to, you know, but it did take in then the consideration, you know, somebody who had been assaulted. I can only go again on my own experience, and my own management, and what I learnt from others about the support that you offered somebody when they were, when they were subject to an assault like, you know, you had to show compassion, and like there's times it wasn't, it wasn't always easy like, and there was probably days that were more difficult than others. But as long as we were seen to be addressing that and looking at opportunities so that that didn't happen again, whether that was do with, you know, more support for the staff, or managing a patient in a different 12:24 12:25 12:25 12:25

way, or reviewing the patient's care and making changes through the multidisciplinary team.

105 Q. If we can go to paragraph 78, please? We've already touched in your evidence this morning upon the introduction of CCTV to Muckamore. 12:26

A. Yeah.

106 Q. Now, you say that there was no CCTV on the wards when you worked on them, but CCTV was introduced to Muckamore when you were there?

A. Yeah. I moved from the wards in April 2017. The CCTV was installed, but we were aware - well, we were informed that it wasn't operational. We all know now that it was operational from I think was it March 2017. So I think the question that I was asked when giving my statement was about did I notice a difference in staff practice from when CCTV - prior to CCTV, and then when CCTV was operational, but the short period of time I had in Cranfield when CCTV was recording, which we weren't aware of, you know, there wasn't a change in behaviour. But then during my time as Day Services Manager it was introduced to the Moyola and the swimming pool buildings, and I certainly, you know, didn't see a difference in staff practice before or after. 12:26 12:27 12:27

107 Q. Did you have any further involvement in relation to CCTV in terms of incidents being brought to you or having to review CCTV during that period? 12:27

A. Ehm, there was one incident within day services that I think there was a viewing. You know, they took

snapshots of environments that had CCTV, and there was one incident that they wanted further clarification on, so myself, my senior manager, and the safeguarding officer sat down and reviewed it, and I think the concerns expressed at the time was when - was a patient 12:28
who was, she was in a wheelchair and was upset, and staff had stood back for a period of two or three minutes and didn't engage with the individual, and whoever was viewing the CCTV had felt that the staff should be doing more. But the care plan to be followed 12:28
was to step back for the two to three minutes. The patient was supported in a room with - there was no other patients there - and then after two/three minutes re-engaged, and that actually happened within the - and the CCTV didn't have any audio, so they couldn't hear, 12:29
it looked as if they were just standing back, but there was communication like during that period. So that was accepted as an explanation like, and there was documentation within the care plan to back that up. But that's the only time I ever viewed any CCTV in the 12:29
hospital.

108 Q. If we could go to paragraph 60 then, please? So I'm going to refer to paragraph 60 and then 64. Apologies, if we could just skip to paragraph 64, please? Yes. Thank you. And here you say that you completed a 12:29
teaching and assessment course at the Northern Regional College, which prepared you for being a mentor for student nurses, and you were allocated specific student nurses during their six or 13 week placements and you

signed off that they had reached a satisfactory standard in their competencies and curriculum. So you were a mentor to student nurses at Muckamore from the 1990s until your retirement in 2020, is that correct?

A. Yeah. Mhm-mhm. 12:30

109 Q. During that time as a mentor, did a student nurse every come to you and express concerns about patient care, or the condition of wards, or anything in relation to practices at Muckamore?

A. No. 12:30

110 Q. And elsewhere in your statement you say that you -- I'll just pull up paragraph 61. Thank you. You say here, third line down, or first line down:

"I do not recall any incidents whereby I witnessed poor 12:30 care. I would have felt confident to report anything I was uncomfortable with to my line managers, but I cannot recall any specific occasion when I needed to."

So you didn't personally witness any incidents that you 12:31 were uncomfortable with in terms of bad practice, or abuse, or poor care?

A. Yeah. Ehm, I think again when the question was asked of me, the question was specifically had I witnessed poor care? It wasn't was anything ever reported to me. 12:31 So there would have been - I can recall two incidents, one in Movilla where a patient had approached a member of - it was a healthcare worker - and said that something bad had happened to him a lot of years

previously, and the healthcare worker had immediately come and reported that to me, and I brought the patient in, they repeated that a staff had physically assaulted them. Ehm, again, I reported that immediately to, it would have been my line manager at the time, and the 12:32
consultant psychiatrist, and the senior social worker for the hospital then came down, and this is prior to, you know, safeguarding procedures that were in place. So I suppose it was the older way of dealing with things. So, there was - the patient was interviewed 12:32
again, repeated the allegations, and then that was reported to the PSNI. I think they were called that then? I'm not sure. Correct me if I'm wrong. But from there then the member of staff was suspended. The member of staff, sorry, had left the hospital, didn't 12:32
work in the hospital, but still worked in the Trust in another facility, and they were suspended for I think it was a period of two years, until the patient then retracted that initial allegation. So that was one incident that was referred to me and I passed on. 12:33

The second one then was relating to a time in Cranfield, which around about 2015, where a member, it was alleged, a member of staff alleged that a patient assaulted -- a member of staff had assaulted a patient 12:33
by pushing them into a chair. Again that was - it wasn't reported directly on that evening. I wasn't on duty, it was reported to me, I was at home the next morning and got a phone call and then that was reported

then. So safeguarding referrals were done and participated in a safeguarding investigation. There was a disciplinary hearing and the member of staff was dismissed as a result of that.

12:33

So those are two, two occasions when something was reported to me, which you had to act on immediately like. The first one, you know, we didn't know it was -- whether it was believable or not, but you had to take it that it was, that it was, and follow 12:34
procedures. The second one was different, where it was a member of staff reporting another member of staff, and then there was a second staff witness.

111 Q. Were you always clear - without going into detail any further with those two incidents that you've provided - 12:34
were you always clear about what your responsibilities were in your leadership roles at those stages?

A. Absolutely. Yeah, yeah. You know you couldn't have something like that happening on your ward like, you know, it was -- and if it did happen it had to be 12:34
reported.

112 Q. With the exception of the two examples that you've just provided, I think it would be fair to say that you, in your evidence today and also in your statement, have painted a somewhat positive or rosy picture of your 12:35
time at Muckamore. Would that be fair to say?

A. I don't know if "rosy" is the right word, but certainly, you know, I've had a long career there and, you know, on the whole it was positive like, yeah.

113 Q. You will be aware of the Terms of Reference and the purpose of the Inquiry looking at abuse at Muckamore, and the Inquiry has also heard evidence in relation to varying standards of cleanliness and issues generally with wards in addition to abuse. 12:35

A. Mhm-mhm.

114 Q. How do you think that that abuse that has come to light happened?

A. Ehm, I can't honestly say how. I'm just flabbergasted that it did happen and it happened in, you know, an environment close to where I worked. Ehm, it was shocking to hear about it, you know. And for somebody who would have shouted from the rooftops how good a hospital it was, and the practice was like, you know, you turn around and now you're embarrassed to say that you worked there like. So. Struggle, struggle to deal with that part of things, yeah. 12:35 12:36

MS. BERGIN: I don't have any further questions about this part of your evidence.

A. Okay. Yeah. 12:36

MS. BERGIN: But I'll just defer to the Panel in case they do?

CHAIRPERSON: No, we've asked the questions as we've gone along. So I think we now need to move into a restricted session, very briefly I imagine. 12:36

MS. BERGIN: Yes.

CHAIRPERSON: So could I ask, please, for the feed to Room B to be cut, and we are now in a fully restricted session.

MS. BERGIN: Yes. Thank you.

RESTRICTED SESSION

OPEN SESSION 12:37

THE INQUIRY RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS:

CHAIRPERSON: Thank you. Yes, Mr. McEvoy. 14:03
MR. McEVOY: Good afternoon, Panel. This afternoon's witness is Mr. Brendan Ingram.
CHAIRPERSON: And no application?
MR. McEVOY: No, no --
CHAIRPERSON: No cipher? 14:04
MR. McEVOY: No restriction applications or any other preliminary matters.
CHAIRPERSON: Excellent. All right.

MR. BRENDAN INGRAM, HAVING BEEN SWORN, WAS EXAMINED BY MR. McEVOY AS FOLLOWS: 14:04

CHAIRPERSON: Could I just welcome you to the Inquiry, Mr. Ingram. Thank you very much for coming along to assist us. Thank you for your statement, which we've 14:05
all read. Normally we take a break after about an hour or so. If you need a break at any stage before that, just let me know. All right.
A. Okay.

CHAIRPERSON: Okay. Mr. McEvoy.
MR. McEVOY: Thank you, Chair. Good afternoon, Mr. Ingram. We met briefly a few moments ago.
A. Yeah.
115 Q. My name is Mark McEvoy and I'm one of the Inquiry counsel team. You have provided to the Inquiry a statement of some, I think 12 pages in length, and it is dated 25th July 2024. Can I ask firstly whether you want to adopt that statement as your evidence to the Inquiry? 14:05
A. Yes, with one minor amendment.
116 Q. Okay. And is that an amendment that appears at or may relate to what is said by you at paragraph 19?
A. Yeah.
117 Q. And what is the amendment? 14:05
A. The amendment really is that the way that it's written at the moment says "A Core Hospital Group was formed"...
118 Q. Could you keep your voice up, please, Mr. Ingram? Bring the microphone over. 14:06
CHAIRPERSON: So this is about eight lines down "A Core Hospital Group was formed"?
A. Yeah.
CHAIRPERSON: Yeah.
A. I just wanted to state it wasn't formed, it was already established and had been meeting for quite a while before that. That almost reads as if I was part of that group. I was invited to the group as and when issues arose that would have pertained to whatever my 14:06

role was at the time. I wasn't actually physically part of that particular group.

CHAIRPERSON: Okay. Well I think that will probably come clear through your evidence. I mean it's right to say that a Core Hospital Group was formed? 14:06

A. It had already been in existence.

CHAIRPERSON: It had already been. Okay. So if we say "had been" instead of "was".

A. Yeah.

CHAIRPERSON: Okay. Thank you very much. 14:06

119 Q. MR. McEVOY: All right. Well thank you for that, Mr. Ingram. Before we do proceed, maybe that brief exchange has just highlighted the importance of keeping your voice up.

A. Okay. 14:07

120 Q. So that the microphone picks up what you say, and we'll try to speak as slowly as we can.

A. Okay.

121 Q. It's not always easy when there's an exchange, but if we try to speak slowly. 14:07

A. Okay.

122 Q. And we'll be reminded if we go too fast to slow down.

A. Okay.

123 Q. So, with that amendment in mind then, we have your statement of the 25th July of this year. And what I'm 14:07 proposing do then, Mr. Ingram, is to summarise some parts of it and scrutinise in a little bit more detail some other parts of it, with a view to getting your account, as it were, onto the Inquiry record in the

form of a transcript. Does that sound okay?

A. Yes, indeed.

124 Q. Well, look, if we start at the very start then. You tell us that your connection with Muckamore Abbey Hospital is that you worked there in various roles from May 1984 until your retirement in June 2020? 14:07

A. Mhm-mhm.

125 Q. It may be helpful just for you to clarify for us what your role or post was upon your retirement in June 2020? 14:08

A. Yeah. When - at the point of my retirement, as far as I recollect, and I think I'm correct in saying this, it would have been Business Service Manager.

126 Q. Right. Okay. And we'll talk a bit about that role and what it entailed then in due course? 14:08

DR. MAXWELL: Can I just ask? So that wasn't a nursing role, that was business services?

A. That's correct.

DR. MAXWELL: When was the last professional nursing role you held? 14:08

A. Ehm, I think I have mentioned it somewhere there. I was on the ward for I think about 13 years. So '84, '94, around '97/'98.

DR. MAXWELL: So since 1998 you were in general management rather than a nursing role? 14:08

A. Yes, yes. Yeah. Yeah.

CHAIRPERSON: Well if you have a look at paragraph 5 it might help you.

PROFESSOR MURPHY: Yeah.

CHAIRPERSON: I think you say you were a Staff Nurse on the wards until 2001.

A. Yeah, that's right.

CHAIRPERSON: Is that right?

A. Yep, that would be right. 14:09

CHAIRPERSON: Okay. Fine. Thank you. Mr. McEvoy.

127 Q. MR. McEVOY: Well, we'll just get a little bit of your personal background onto the record then, Mr. Ingram, and you describe how you had a family member with a learning disability and you were therefore well used to 14:09 caring for people with a learning disability from the age of around 5, and you set out some recollections of helping out at that family member's day care centre from a young age, and had an interest in that type of work. You lived in Fermanagh as a child, and other 14:09 than the day care centre that your family member attended, you had no idea of how to start a career, but you made enquiries and you became a State enrolled nurse. You wrote a letter to Knockbracken Training School to advise you wanted to be considered, and then 14:10 in May 1984 you became a student nurse at Knockbracken Training School. After that you had a number of placements at Muckamore during this training, which took about 18 months, after which you qualified as a State enrolled nurse. You worked at Muckamore as a 14:10 State enrolled nurse for about a year. You think that you may have begun in Moylena Ward. You went back to Knockbracken and then went on to complete a number of placements in Muckamore after that. Due to the passage

of time you can't recall which wards you worked on during your training, but you think you were placed in Moyola, Moylena and Movilla A and B Wards. You qualified in the late 1980s, around 1987 or 1988. You were interviewed for the roles of State enrolled nurse and registered nurse in mental health, and you were successful in taking up those positions at Muckamore.

14:10

As I've just touched on, you spent 13 years as a Staff Nurse on the wards in Muckamore from in and around 1988 to 2001. You worked as a Grade D/E Staff Nurse during those 13 years. You can't recall which wards you worked on and when, but you recall working on the vast majority of the wards that existed during this timeframe. You cared for patients with varying degrees of learning disabilities from mild through to severe, and your daily responsibilities depended upon which ward you were on and the degree of learning disability of the patients.

14:11

14:11

For patients with severe learning disability the role of a Staff Nurse was to provide care for all the daily needs of the patients, from getting up in the morning, washing, feeding, dressing, and so on. Other staff came on to the ward, such as physios and dieticians, and you assisted them with whatever they needed from a nursing perspective. You describe how Muckamore had its own day care centre and you accompanied patients to the day care centre for daily activities.

14:11

In the 1980s, Muckamore was like a small self-contained village. Some patients with milder learning disabilities had jobs which they left Muckamore to do, to attend during the day, and there were workshops for patients on-site.

I suppose picking up on the matter of activities towards the end of that paragraph then, Mr. Ingram, we've had evidence to the Inquiry from both family and staff witnesses describing how there were very rarely activities on wards, and the Inquiry would be interested in your view about that, and I suppose if we can take it in two parts? Maybe first of all how things were before 2001 and then afterwards? Can you help us with that? 14:12

A. Yeah, I can. My recollection, and I suppose as you quite rightly say there is two parts to this, in that the very specific day care, or day-time as it later became known, opportunities for patients on the ward, were in specific buildings other than the wards. So there were buildings on the site where patients left the wards to go to participate in day-time or day care activities. Ehm, and that would have been a fairly wide range of activities, and so on. There was also opportunities on the ward -- now, when I say "on the ward", it wouldn't have been the type of activities that would have been completed within the buildings external to the wards, it was more like tabletop 14:12 14:13 14:13

activities, reading, taking patients for walks, taking them on shopping trips, things like that there which weren't directly related to the external activities to the ward in the buildings that were also on the site. So there was a distinct difference between what you called "on ward activity" and "off ward activity".

128 Q. Okay. And what you have just described as the position or how things were before 2001?

A. Ehm, well, that would have been my experience of both.

129 Q. Right. Throughout? 14:14

A. Throughout.

130 Q. Okay.

A. Yeah. Yeah.

131 Q. And so when the families have described how they felt that there were very rarely activities on wards, what would you say about that? 14:14

A. Ehm, I don't know to what period the families are referring, so it's difficult to answer that question. Certainly my recollection would have been that there were on ward activities. 14:15

132 Q. You then go on and describe how, and this back in your nursing days, on occasion you were responsible for administering medication and rostering staff. You describe an allocation system for staff on the wards where patients would be split into different groups and staff allocated to them accordingly. 14:15

A. Mhm-mhm.

133 Q. Pausing there. Was there a basis in those days for splitting patients into different groups?

A. Was there, sorry?

134 Q. Was there a basis? On what basis were the patients split into different groups, if there was one?

A. Ehm, there was no specific basis. The way it would have operated was that, for example, if you had we'll say 20 patients on your ward, and five staff who were going to be working, if you like on the floor, it was literally, four, four, four, four. 14:15

135 Q. Right.

A. There was no specific basis for how the patients were allocated into the various groups. 14:16

136 Q. Yeah. Okay. Then you go on to describe your recollection of the duties involving patient care and non-patient specific care duties, such as laundry. Roles were recorded in the allocation book which was reviewed by all members of staff at the start of the shift. You describe attending to administration roles, such as ordering supplies and keeping patient notes up-to-date. You describe how during your time on the wards all patient notes were handwritten. There was no real system of filing of patient's notes other than completing forms and placing them in the file on top of all the other notes from various disciplines. 14:16 14:16

Then you describe supervising meal times, as did all staff on the ward, as there were various risks such as that of choking, or patients taking food from one another which could have led to aggravation. 14:16

Then you say that you absolutely loved working on the wards in Muckamore. You describe how you felt supported in your role as a Staff Nurse and it was a really good place to work. The teams on the wards were tight-knit with the intention of helping each other to provide the best care possible for the patients. You say that if you ever needed any help or support you felt that you could ask for it and it would be given to you. You say that you regularly went into Muckamore unpaid during your time off to give an extra pair of hands to help out. You were not the only member of staff do that. 14:17 14:17

Pausing there. On what basis did you go into hospital unpaid? 14:17

A. Ehm, I can explain this quite clearly. At the time, because I lived so far away from home, there was what was known as "nurses homes" at the hospital. So, for example, depending on how your shifts were rostered and so on, on a day off, for example, because it was so far to go home for the sake of one day you may have stayed just literally in the hospital grounds in the nursing homes. And I can remember on numerous occasions, and it was pure voluntary, I wasn't asked to come in, or I wasn't required to come in, or I wasn't needed to come in, but it was, it was something that I wanted to do. I enjoyed going in. I was able to help out when I went in, and it would have involved things, for example, like taking patients out on a bus run, or going out for 14:17 14:18

a walk, or going down the town or whatever, but it was purely voluntary, it was at my behest and not at the behest of having to be there, or being called in or whatever, it was purely a voluntary thing.

137 Q. So no question of you being required because of staff shortages? 14:18

A. Absolutely not, no. No.

138 Q. And help us understand a little more. You were unpaid, it was voluntary, you describe taking patients on bus runs and things of that nature. But were you doing anything more, shall we say clinical, in terms of conducting yourself as a nurse? 14:19

A. Yeah. Well you would have done that sometimes, yes, absolutely. And, again, it was literally as an extra pair of hands on the ward. 14:19

139 Q. Mmm.

A. So, yeah, it was a combination really of both.

140 Q. And you weren't the only member of staff to do that?

A. No, there were other people in a similar type situation as myself, because possibly the distance they lived from home or whatever. If, for example, the way your roster worked out that you were off for the two days, it was more likely that you went home. 14:19

141 Q. Yes.

A. But if it worked out that it was split days in the week or something, it just wasn't worth going home for that one day because you had to be back for the next day and so on. So, yeah, there were other people in the same type of situation as myself and would have done that 14:19

type of thing.

142 Q. And was this during the whole of that period from 1988 to 2001?

A. No, no. No, no. It would have been in the first couple of years. 14:20

143 Q. Okay. You then mention a well known complaints procedure in Muckamore for staff. You say that you personally never had to invoke the complaints procedure yourself, but you know of other staff members who did use it and you do not know anyone who did not receive a satisfactory outcome. 14:20

DR. MAXWELL: Can I just ask, is this also known as a grievance procedure? Is that how it would be referred to in the policy?

A. Ehm, possibly, yes. Ehm, I'm not aware of a separate grievance procedure, so, yes, I would presume that the two are the same, yeah. 14:20

144 Q. MR. McEVOY: Do you know the types of things that it covered, can you recall? Types of topics or issues that it would have covered? 14:21

A. Ehm, my recollection of it is that it has actually covered everything. If you felt that you had a complaint of any nature, regardless of what the complaint was, that that was the process to be used.

145 Q. And when you say that you know other staff members who did use it, you don't know anyone who did not receive a satisfactory outcome, can you help us understand what you mean by that? How do you know about other people using it? 14:21

A. Well people would have talked at that time and so on. Things would have been shared amongst staff. It wasn't uncommon for -- I suppose I should probably state that we need to understand that there was a process of sort of informal and formal complaint.

146 Q. Yeah.

A. Formal complaint would have been more when it went down the entire official route and involved writing a complaint and so on.

147 Q. Yes. 14:22

A. But there was also, you know, complaints where it never made it as far as an official route because it could have local resolution before it would ever reach that stage. Ehm, one example that I can think of just back to the time was, if, for example, a staff member had 14:22 requested a specific day off and didn't get that day off, which, you know, for possibly genuine or, I don't know non-genuine reasons would have happened from time to time, they would have felt aggrieved by that, and that was probably more an unofficial complaint. I'm 14:22 not even sure you would describe it as a complaint, more so of a grievance nature. Ehm, the complaints process was where it was actually put in writing and it went through the official channels of being an official complaint and so on. Ehm, I have very little if any 14:23 recollection of anybody ever having to use that particular aspect of it, the official route.

148 Q. I mean many work places would have an informal and a formal grievance or complaint type process for

employees to use.

A. Yes. Yes, yes, yes.

149 Q. One sees you mention a you well known complaints procedure, I suppose it would be helpful to know what you're talking about there. Is this a formal or an informal? 14:23

A. That's the formal.

150 Q. Right.

A. The formal.

151 Q. And you are aware of people using a formal procedure? 14:23

A. Yes, but I wouldn't remember at this stage what they were using it for.

152 Q. Right.

A. But, yes, there was a very formal, and that would have been explained to you as part of your induction to hospital. 14:23

153 Q. Yes.

A. To if you were moving wards, whatever. But, yes, there was a very official formal complaints procedure.

154 Q. Okay. And you've given a description there of, you know, the very classic example of an employee using it over a leave issue? 14:24

A. Yeah, yeah.

155 Q. Or something that's rudimentary, for want of a better word. 14:24

A. Yeah.

156 Q. But what about, for example, where an employee had seen something untoward in the nature of, for example, a colleague behaving inappropriately in terms of their

handling of a patient?

A. Not in my time.

157 Q. Would it have been understood that you could have used this process?

A. I'm not entirely sure they would have used that process as such as opposed to going directly to the Ward Manager, or whatever, and giving an account and a description of what they had witnessed. 14:24

158 Q. Yeah.

A. Ehm, I'm not entirely sure on reflection that that's what the purpose of the complaints procedure would have been. I think had that happened and so on, and it would be my recollection I think if I had noted it at the time or whatever that I would have went directly to the Ward Manager, I wouldn't be starting to write a complaint as such. 14:24 14:25

159 Q. Right.

A. I don't view that as a complaint, if there has been an issue where a staff member has been -- I'm not sure, I can't remember what words you used there, but whatever the scenario was. 14:25

160 Q. Yeah. Okay. So it would have been your understanding then during this period up to 2001, during your nursing days if we can put it that way.

A. Yeah, yeah. 14:25

161 Q. That if there was an untoward incident, and I've given you a specific example of staff on patient inappropriate conduct or abuse?

A. Yeah. Yeah, yeah.

162 Q. It would have been your understanding that a nurse or staff member should report that to the Ward Manager?

A. Yes, absolutely.

163 Q. And would that be written down anywhere?

A. By the person who witnessed it? 14:25

164 Q. That understanding that you had, is that borne of it being written down anywhere?

A. Oh, that would have been all included within the induction that you got into the ward or whatever.

165 Q. Right. Now, you say then at paragraph 8 that "As noted above" you can't recall what wards you worked on and when. You never noticed any differences in culture between different wards. The atmosphere on all wards was good and positive. On a personal note you say that you believe the patients were very well looked after. You say: 14:26 14:26

"All staff went way over and above what was expected of them to deliver the best care they could. The patients had a wide variety of activities." 14:26

You never noticed any differences on the approach to the general treatment of patients between wards, other than the care was patient-centred and appropriate for the level of learning disability the patient had. And you say that you never noticed any change in atmosphere in wards with different staff being on duty. 14:26

I wonder could the paragraph be brought up on screen

just for everybody to see, if that's possible? I just noticed that it's not appearing up there.

CHAIRPERSON: No, I was just going to ask where it was.

166 Q. MR. McEVOY: Yes. Thank you. So I've just read that out for everybody's benefit. Taking it up there, Mr. Ingram, you don't observe any difference in culture between wards, nor do you recollect witnessing poor care or abuse. But were you aware of the opinions or accounts of others that some wards had poor care practices? 14:27

A. I don't recollect any of that there. I suppose when I was preparing this statement I was taking it from my own personal experience.

167 Q. Yeah.

A. And I suppose to say in fairness, while I don't recollect a lot of the wards, I certainly do remember the wards in the sense of who they were, what they were, and the type of patient that was in them, and I think you read out a bit earlier there where I had said that I worked across most of the wards. The only exception I would make to that was probably the children's wards, I don't ever remember having worked in those. And when I say that I worked in all the wards, it wouldn't have been, you know, on a permanent basis. There might have been days from time to time where - and the word that was used at the time was "relief staff" being sent out on relief - so where a ward was possibly short, maybe somebody had phoned in sick or whatever the reason might be, you might have

been asked to go and do your shift in that particular ward. So it was, you were sent out on relief. And that's why I say in the paragraph that you've just read out, I genuinely did not notice changes in cultures. I didn't notice changes in staff. And on the ward that I would have been probably permanently working on at that time, I certainly didn't notice any of that there. I did allude earlier there to the fact that, you know, the teams were very good, they were very tight-knit. To this day I can still remember where we went above and beyond what our role and remit would have been. So, no, never noticed any difference in cultures or changes in staff teams or anything like that. 14:29 14:29

168 Q. And we know, because you go on to tell us and we'll turn to it shortly, but we know that after your, the end of your nursing days at Muckamore, you went up the ranks, as it were, in terms of managerial responsibility, and you moved across from a nursing role to management? 14:29

A. Yeah. 14:30

169 Q. But you were still very much based in Muckamore, isn't that right?

A. Oh, absolutely, yeah.

170 Q. Yeah.

A. Yeah. 14:30

171 Q. Would the same sentiments that you express in paragraph 8 about your views about how the patients were very well looked after and positive atmosphere on the wards still obtain to the period after your nursing, the

nursing part of your career?

A. Did it still pertain to?

172 Q. Yeah. Post 2001 let's say, through to your retirement?

A. Post 2001. Certainly initially I would answer that question by saying "yes". Obviously I became aware of difficulties in latter years of things, difficulties, if you like, which related mostly to staffing levels and so on around the wards. Even though I wasn't working on the wards I would have been aware of that fact, yes. 14:30 14:31

In terms of the care of the patients, I probably would have been aware as well that there wasn't, if you like, the same levels, for example, of activities, either on or off the ward, and that obviously was very much down to staffing levels and so on. In terms of the actual physical care and so on that was being carried out, I couldn't really make a lot of comment on it because I wasn't party to it, I wasn't on the wards, I wasn't witnessing it, but certainly in the number of years after I left the wards as such, I wasn't aware of anything that was negative, if you like. 14:31 14:31

CHAIRPERSON: But so far as a drop in staffing levels, you say you were aware of that post 2001?

A. Later again than even 2001, because in 2001, when I left, the staffing levels were pretty good. It would have been much later than that when staffing levels became a huge issue. And as a result, as I say, I would have been aware that, for example, the level of 14:32

activities on or off ward wouldn't have been as good as, for example, pre-2001 when I was on the wards myself.

CHAIRPERSON: You had become aware of that in a management role. 14:32

A. Yeah, but becoming aware is becoming aware from hearing people saying it on the site and so on.

CHAIRPERSON: Yes.

A. It wasn't from witnessing it, as such. Because, as I say, I wasn't on the wards. 14:32

CHAIRPERSON: No, I understand. I understand.

DR. MAXWELL: And --

CHAIRPERSON: Sorry, can I just - if you let me just finish one point. You mentioned earlier tight-knit teams. 14:32

A. Mhm-mhm.

CHAIRPERSON: First of all, what do you mean by that and was that affected by the fact that you had a lot of -- were you aware of there being a lot of familial relationships? In other words, people with family members working together? 14:33

A. Mhm-mhm. Well first of all I would say I had no family connections to the hospital whatsoever. I would have had limited knowledge of familial connections and so on, and what I meant by "tight-knit" was that, if, for example, you as one individual staff member had a certain number of tasks to perform for that one shift that you were on, if you were falling behind time-wise and so on and weren't getting time to get everything 14:33

done that you either had been asked to do or wanted to do yourself, others would have helped.

CHAIRPERSON: So the normal give and take thing that you expect.

A. The normal give and take. Absolutely. And that's what I mean by "tight-knit", people would have helped each other, would have been, you know, happy to help each other, and it wasn't a case of where someone was saying "Well, look, that person is falling behind, will you go and give them a hand out or whatever", it was a case of "Look, I know you need a hand, I'll give you a hand." 14:33 14:34

CHAIRPERSON: Sure. Yeah. Sure. And were you aware of familial relationships on the ward when you worked there?

A. Very limited knowledge. Very limited. 14:34

CHAIRPERSON: Very limited.

A. Yeah. In latter years I would have been more aware.

CHAIRPERSON: Sorry, in latter years you would have been?

A. You know, say probably more post 2001 to be honest with you. 14:34

CHAIRPERSON: And do you know why that changed?

A. Sorry, I'm not sure I understand what you mean?

CHAIRPERSON: I was asking you about familial relationships on the ward. 14:34

A. Yeah.

CHAIRPERSON: You said you had very limited knowledge, and then you said "In latter years I would have been more aware".

A. I assume you're referring to family connections?
CHAIRPERSON: Yeah.
A. Yeah.
CHAIRPERSON: In the staff.
A. In the staff, yeah. There were certainly a number of families, but at that stage I think you could have counted them on one hand where there would have been more than one member of the family, if you like. 14:35
CHAIRPERSON: But that's five families.
A. Sorry? 14:35
CHAIRPERSON: Potentially five families.
A. Yeah, yeah.
CHAIRPERSON: Yeah. Okay. All right. Thank you. Sorry, Dr. Maxwell.
DR. MAXWELL: So you were saying that staffing wasn't really a problem when you were working clinically on the wards, but you became aware later that there were problems, and the Inquiry has heard some evidence of that, being on the Risk Register certainly in 2012. In the general sort of conversation in Muckamore, why did people think staffing had become a problem? Why did you go from not having any problem recruiting sufficient staff, or retaining sufficient staff, to actually finding it challenging to staff the hospital? 14:35 14:35
A. Ehm.... 14:36
DR. MAXWELL: Because people would have had views about that.
A. Yeah, yeah. No, no, no, absolutely. I suppose in the last what, four or five years possibly before I

physically retired, it was very clear why there was difficulties with staffing, because so many were leaving.

DR. MAXWELL: But I'm talking about maybe from 2001 to 2013? 14:36

A. But the staffing -- it's very difficult -- I don't honestly remember today when, in what year as such. It wouldn't have been 2001, because staffing levels were still pretty good.

DR. MAXWELL: Yeah. 14:36

A. After I left the wards.

DR. MAXWELL: Yeah.

A. I'm not sure just exactly what period or what year that that would have started to deteriorate.

DR. MAXWELL: But do you think it was because you weren't recruiting new people, was it because more people were coming to retirement age? 14:37

A. I do recollect that in terms of recruitment and the number of people who were being trained I think was a lot less. 14:37

DR. MAXWELL: So the supply of staff went down.

A. Yeah. Yeah, yeah.

DR. MAXWELL: It wasn't because people were unhappy or retiring?

A. Not at that stage, no. 14:37

DR. MAXWELL: Up to sort of 2013.

A. Aye. Aye. Not for those reasons, no.

DR. MAXWELL: Okay. Thank you.

173 Q. MR. McEVOY: At paragraph 9 then, again we're talking

about your recollection of your nursing career, you were made aware of the purpose of each patient's admission and you had a good idea of their skills, challenging behaviours and risks, and you would have had that prior to or immediately upon admission. 14:37
Detailed information would have generally been supplied by family members, Social Services, and community staff. Consultants also had a lot of information as they were consultants both in the hospital and in the community, and therefore they had a lot of knowledge or 14:38
patients.

Pausing there. During I suppose all of your time in the hospital, do you recall or can you help us understand whether the role of consultants in the 14:38
hospital changed in terms of the relation, in relation to the frequency of their presence on the wards and their general sort of understanding and familiarity and overview of the patients?

A. When I think back to my time on the wards, the 14:38
consultants were more so based in the hospital than in the community. So you would have seen them fairly regularly around the wards. Not necessarily every day, but quite frequently. And alongside the consultants they would have had a junior doctor who worked 14:39
alongside them, and that junior doctor, that junior doctor would have visited the ward every day and there would have been what was known as a ward round. So essentially if there were patients, for example, that

you wanted to discuss with the medical staff, you would have done that on a daily basis. And then once a week there was what was known as a ward conference, and that would have been, if you like, led by the consultant responsible for the patient. 14:39

174 Q. Yeah.

A. So there would have been the consultant, junior doctor, Ward Manager, possibly other AHPs that may have been involved, nursing staff, day care staff. So it was pretty much a multidisciplinary type meeting, and that would have occurred at least once a week. 14:40

175 Q. Mhm-mhm. But did that change? I think what we're sort of trying to gain an understanding of was, from your perspective did you notice a change over the trajectory of your time? 14:40

A. That would have been very much -- what I have just described would have been the case up until certainly I left the wards, but I think I'm correct in saying that post-2001 that would have changed in that the consultants weren't as much in the hospital because they were sharing the hospital with the community and they wouldn't have been as available in the hospital as what they had been pre-2001. 14:40

176 Q. Yes.

A. For my time I mean. For my time. 14:41

177 Q. Now, on down in the same paragraph you say that essentially between 1984 and 2001 there wasn't a high level of admissions or discharges to the wards you worked on in Muckamore.

A. Mhm-mhm.

178 Q. And most of the patients had been there for a very long period of time. Once a patient was admitted you were involved in assessing the patient's needs as part of a wider multidisciplinary team, which I think is what you were touching on there. 14:41

A. Mhm-mhm.

179 Q. And you recorded observations in the patient's notes. Now, there was a low level of admission and discharge prior to 2001. What do you think, I mean the Inquiry has heard extensive evidence that things changed quite substantially in the years after that? 14:41

A. After?

180 Q. After 2001.

A. Yeah. 14:41

181 Q. That there was a change in the type of patient?

A. Yeah, yeah. Yeah.

182 Q. And their needs into the hospital, can you help us from your own perspective understand what might have brought about that change? 14:42

A. I think this is probably a fairly lengthy story, to be quite honest with you, why that change was coming about and so on. Obviously, when I say there was a low level of discharges and so on, that was essentially because the patients who were there were there for lengthy, lengthy periods of time. But as I suppose resettlement rolled out, and so on, a lot of those patients were being moved into community care, and obviously then that was freeing up capacity within the hospital for 14:42

new admissions. But I think what we need to understand here as well is that with the new core hospital coming on-line, and obviously there are so many back stories to this which I'm not totally familiar with, but I can certainly say with some confidence that with the new core hospital there was the understanding, if I can put it that way, that, you know, it was going to operate totally differently to what Muckamore Abbey Hospital as a whole had been doing up until then. 14:43

183 Q. Yeah. 14:43

A. In that the new wards, for the want of better words, were going to be assessment and treatment, and very much the view that, you know, this idea of people being in hospital for long periods of time was no longer going to happen. Now it didn't always materialise that way, I might add, but certainly the thinking at that time was that if you were living in the community you had a breakdown of whatever, be it your mental health, your behaviour, your whatever. 14:43

184 Q. Yeah. 14:44

A. You would come into hospital, have a period of assessment, if necessary a period of treatment, and you would go back out to where you came in from.

185 Q. Yeah.

A. The type of patient changed in that -- 14:44

186 Q. I was going to pause you there. For your own assistance if you look across to paragraph 19 - we'll will come back to the other paragraphs - it's just because it picks up on I think the point you're making,

and it might just be as well to take it up here.

A. Yeah.

187 Q. You said that the patients at Muckamore changed over the decades in the '80s, '90s, and 2000s - just as you have made the point and I have read it back there, were in the hospital for a long period of time. 14:44

A. Mhm-mhm.

188 Q. Later into the 2000s and into the following decade, patients being admitted into the hospital were becoming more aggressive and many of them with drug dependency and the admission of forensic patients. 14:44

A. Mhm-mhm.

189 Q. Then you go on to make the point about a high degree of patient-on-patient and patient-on-staff incidents and what that meant for the police locally in the area, apart from anything else. 14:45

A. Mmm. Yeah.

190 Q. And we'll come on to the Core Hospital Group shortly. But I suppose you've described in both of those paragraphs, 9 and 19, a change in the type of patient into the hospital. Do you know where patients with, for example, drug dependency and challenging behaviours, would have gone before 2001? 14:45

A. I think largely to mental health units.

191 Q. Yeah. And from your perspective can you give an explanation, or can you give us the explanation, such as it may have been, that was given to you for this shift in the type of patient coming into the hospital? 14:45

A. Yeah. Ehm, my understanding, and again this is from

just listening to conversations, as you're aware I was off the wards by this stage and so on, was that --

192 Q. Can you speak up just a little bit?

A. Sorry.

193 Q. You're okay. 14:46

A. That there was more sort of assessment type things happening in the community where, you know -- I'm trying to think how you word this. The people who were probably being missed beforehand were now being assessed by learning disability staff, be it 14:46 psychiatry, be it psychology, be it whatever. So more people were being picked up at that point, rather than going to mental health units or whatever, and I suppose at that stage then there was, you know, the very specific facility, if I can put it that way, for these 14:46 people to be admitted to. So that with the new wards that was what that was designed for, to bring those type of patients in to. And as I've alluded to, they would have come in for a period of assessment. If need be they would have stayed for a period of treatment, 14:47 but the overall aim was always to return them back to whatever it was that they had come from.

194 Q. And as the first decade of this millennium rolled on, and the one following that, you were going up the management gears in the hospital? 14:47

A. Yeah.

195 Q. Did you harbour any concerns about this change in, in the type of patient, and whether or not Muckamore was properly equipped to cope with patients with this

degree of need and dependency, given your experience of the earlier part of your nursing career?

A. Ehm, yeah. I suppose from my, and it would be from a personal point of view as opposed to anything else, the type of patient that was coming in, yes, was completely different to what I would have been familiar with. My concerns would have been, for example, around, "Well, look these patients are coming in. Have we given any consideration to the additional needs that these patients have? Have we given any consideration to the additional resources that may be needed for these patients?", and I'm not convinced, certainly from what I had seen, and what I was listening to and so on, that that was always the case. And I suppose going back to one of the points that was made earlier, definitely in the latter years that would have been part of the reasoning for staff starting to leave the facility. 14:48 14:48 14:48

196 Q. Yeah.

A. There were - and I would be aware that probably yourself, the Chair and the Panel, over the long time that you've been sitting, have heard many, many, many stories about the difficulties that staff would have faced in managing some of these patients. They were quite difficult with extreme challenging behaviours and, you know, I just think it was all contributory and, you know, there wasn't I think total recognition taken of that fact that here we are dealing with a different type of patient, but we're not really looking at the staffing, or the patient's additional needs, or 14:49 14:49

what extra resources you might need, or whatever. And as I say, that's a personal, a personal opinion or view.

DR. MAXWELL: As far as you are aware, when the change was made, the core hospital was going to be an assessment and treatment centre, people were going to go there rather than to a mental health facility, increased need was being identified in the community, so people were coming for assessments. What preparation was done with the staff who, as you've described, were being expected to work with a very different type of patient? Did they get additional training and support? 14:50 14:50

A. I honestly in all, I couldn't comment on it because I wasn't part of that. 14:50

DR. MAXWELL: You didn't. Okay.

A. At that time. And I'm not aware of what they would have been told or, you know, how they were prepared, if you like. I just don't know.

DR. MAXWELL: Okay. So in your general management roles were you part of creating the Risk Registers for the hospital? 14:51

A. Eh, no. No, no, no.

DR. MAXWELL: Okay.

197 Q. MR. McEVOY: Paragraph 10 then you describe how - again your recollection of the nursing half of your career. Welcomed family involvement and patient care in the hospital. You describe how there were two types of families. There were a significant number of patients 14:51

in the hospital who either had no family or family who visited them very often, perhaps only a couple of times a year, whereas there were other patients who had visitors three or four times a week. Families were generally supportive of the work that was being done and did quite a lot on the wards themselves when they visited, such as holding fundraisers and so on. Families, in your recollection, were welcomed when they came into the wards. 14:51

14:52

Now, the Inquiry has heard a fairly substantial volume of evidence from a range of patients, and more particularly their relatives and family members, about not being made to feel welcome on wards and, indeed, never even seeing their relative, their loved one's bedroom, personal surroundings, maybe never getting beyond much more than a makeshift visiting room. Can you help us to understand, could it have depended on what ward that the patient was on? That you've got one recollection, which is a positive one, and I've described to you pretty much the reverse. Could it have come down to what wards you were on and what staff were on duty, is that a possibility? 14:52 14:52

A. I think you and I are referring to two different things, in that when I say here that was pre new hospital. 14:52

198 Q. Right.

A. If I understand you correctly, some of those issues that you have just mentioned may have pertained to the

new wards.

199 Q. Right.

A. I have no, nor did I ever hear of any families being refused admission to any part of a ward that I ever worked in. Don't get me wrong, there were visitors rooms, and most families would have accepted the fact that that's where they had their visit with their relative or whatever. I do remember a couple of families that I would have been quite familiar with and so on who would have went to where the patient actually slept. Now that could have been a side room, that could have been a main dormitory, and they would have went down and, you know, sorted out their clothing, took clothing away, replaced clothing, brought in clothing. So that doesn't ring true for me as such. I have no experience of that. 14:53 14:53 14:54 14:54

200 Q. It is important though that I do emphasise I deliberately didn't put a time frame on the point that I was putting to you.

A. Yes. 14:54

201 Q. Because I was interested just to hear your answer.

A. Yeah. Yeah.

202 Q. Now if your answer is that well you weren't aware of anything of that nature during your own nursing days...

A. Yeah, yeah. 14:54

203 Q. But you are aware of those sorts of issues post the setup of the new hospital or the core hospital, then that's a different matter. Is that what you want the Inquiry to understand?

A. What I'm saying is, it didn't happen on the wards that I worked on in my time.

204 Q. Right.

A. But I believe from when the new wards were up and running there may have been cases of that. Again, I can't... 14:54

205 Q. Yes.

A. -- hand on heart say to you today "yes, that definitely happened", because I wasn't on the wards, but I certainly would have been aware of people having said things like that. And the reason I say that is this: I'm not quite sure what time period this was, but certainly within one of the management roles that I would have held we were asked to look at service improvement and so on and, we - sorry, I had come up with an idea of -- and I know yourself and the rest of the people in the room have heard about patient groups within the hospital. 14:55

206 Q. Yes.

A. But you probably haven't heard too much about family groups in the hospital, and I had established this one particular group, and the name which totally escapes at the moment, it was something like "Have Your Say" I think, and I wanted to do this as a Service Improvement Project, because at the time I was very conscious "Well, like, we don't actually have anything here where families can come along as a group", and I don't mean as individual patient families, I mean groups of families coming together and having their say on 14:55

different things. Now that did, I suppose, coincide with the establishment of the new hospital, but during that - I can't remember how many meetings I had with them and so on - but that certainly would have filtered through that they would have liked to have seen, or liked to have been able to have gone to the patient's bedrooms and so on. So, yes, that --

207 Q. So you are aware of it being an issue?

A. Yes, that would have reinforced the fact that it probably was happening, as far as I understood it. 14:56

208 Q. Okay. We've quite a bit to get through so perhaps we should try to make progress. At paragraph 11 then, you are talking about the use of restrictive practices and what you can recollect about them. You say that in your own nursing time they weren't as structured as they later became. You do recollect holds called "care and responsibility" and then later holds called "MAPA". You weren't on the wards when MAPA was used. You don't recall receiving any training on the care and responsibility holds. They were rarely ever needed or required. Did you ever have cause to use care and responsibility? 14:57

A. I mostly likely would have.

209 Q. Yeah.

A. I would be very, very surprised if I didn't have reason to at some points in the time I was on the wards. 14:57

210 Q. Yeah.

A. Generally speaking, however, there are wards at that time were that would never have been needed or

required. One such example, there's one ward which sticks out very much in my mind where it was elderly, wheelchair bound, bedbound, so on and so on, there would never have been a need for either care and responsibility, or MAPA as it became in latter years. 14:58

211 Q. Yes.

A. In the likes of Movilla A and Movilla B, for example, where that was the male admission units, and there were young, young men, if you like, I would have no doubt that I would have been involved in care and 14:58 responsibility during the time that I spent in those two wards. But as to who the patients would have been, or when it happened, or what reason we used it for, I just wouldn't recollect that at this stage. But I've no doubt that I would probably have used it, yes. 14:59

212 Q. And you describe how you generally considered restrictive practices and the order you would need to use them, starting with the least restrictive and working your way down the list.

A. Yeah. 14:59

213 Q. Starting with distraction, measuring the patient's responses and their behaviour, and you make reference then to the use of PRN and seclusion, only used under guidance and advice and the prescription of a doctor consultant as a means of last resort? 14:59

A. Yeah.

214 Q. In the absence of training, how did you know to escalate, as it were, up or down the scale as necessary in terms of the restrictive approach to be used? How

would you have known about that if you weren't trained?

A. Well that from my part anyway. If I remember correctly, was down to I suppose experience, and I suppose if I try to explain? When we say "escalating" or "de-escalating" or whatever, we have to understand 15:00
every situation was an individual situation and every patient was an individual patient. You can't try to group these things together, because no two patients are the same. So a patient who you believe or think is starting to escalate, you could sometimes have diffused 15:00
that very quickly by taking them away from a situation, taking something that was causing the issue away by - there was so many various different methods. It could have been as simple as "Look, do you want to come with me and get a cup of tea", or whatever. 15:00

215 Q. Yeah.

A. And that was enough to diffuse the situation. It wasn't a case of where somebody just suddenly got off their seat and started, you know, hitting out, or kicking, or biting, or whatever. So, you know, there 15:00
was all different levels.

216 Q. But essentially what you're describing there is being, it being left to you to use your judgment in something like care and responsibility, your own on the spot judgment, rather than having formal training. Is that 15:01
right?

A. I think a lot of that would have come via experience and working on the wards with the patients, getting to know the patients, knowing what triggers there might

have been. I could give you an example for - which I certainly distinctly remember. If a family relative had said "Look, I'm coming to visit you on Sunday", and they didn't come, that was a trigger for potentially that person to become aggressive or whatever. 15:01

217 Q. Yeah.

A. And sometimes rather than allowing it to get to a stage of full scale aggression, you could do other techniques that would have distracted the person from having to go to that stage. 15:02

218 Q. Yeah. Okay. And then in paragraph 12 then, you know, you talk about examples of good patient care delivered every day, you give an example in relation to P97, and I think we can summarise it in this way, and that's a patient with significant reclusive behaviours and not 15:02 socialising or indeed really coming out of his room. Then you describe how using a multidisciplinary approach with psychology and psychiatry and eventually being able to get this situation where you could get that - after two and a half years get that patient to a 15:02 position where he could go for a home visit to his parents. And then you describe how there were numerous patients - I'm at the bottom of paragraph 12 now on page 5 - numerous patients in Rathmullan and Rathmore with very severe learning disabilities and of high 15:02 dependencies who way exceeded their life expectancy, and you believe that that was due to the care that they received in the hospital.

At 13 then you say:

"I never personally witnessed anything that I would describe as poor care or abuse in Muckamore when I worked on the wards. As I will get on to later in my statement, I did witness poor care and abuse on CCTV recordings, which form part of my role later on in my career in Muckamore."

Chair, I'm just noticing the time. I'm content to keep going, but it's 3:00 o'clock? 15:03

CHAIRPERSON: Yeah, I think if we can go on for another sort of 10 minutes or so. Is that all right with you?

A. Yes, absolutely.

219 Q. MR. McEVOY: Thank you very much. So, Mr. Ingram, I just wanted to give you an opportunity perhaps to help us understand maybe a gap in terms of the time frame there, and obviously you're talking about your own time on the wards, and then I suppose fast forwarding through then to a period in 2017 and following, when you were dealing with the issue of the CCTV recordings. But by the mid 2000s and teens, shall we say you were in the management hierarchy at Muckamore? 15:03

A. Yeah.

220 Q. And so presumably you would have been aware of issues that were affecting parts, wards, and teams within the hospital, would that be fair to say? Fair to expect that you would have been aware of those types of issues? I'll give you more detail on what I'm keen to 15:04

hear your evidence about.

We heard -- just by way of example we heard evidence yesterday from a former staff member at Muckamore, a senior nurse, and what that nurse described was an environment within the Erne Ward, and this is just really for your own recollection and reference.

A. Yeah, sure.

221 Q. And she talked about her own experience on the Erne Ward, she described the physical environment as "horrendous" and that it was distressing that patients were being nursed in this environment. She said that it felt unsafe and there was a lack of oversight by any senior management and a lack of governance. Do you recollect hearing about issues on the Erne Ward? 15:04 15:05 15:05

A. Ehm...

222 Q. This is in around 2016 I should say?

A. Yes, I do recollect hearing things, but it would have been on an informal basis, not on any sort of formal basis. 15:05

223 Q. Now, what do you mean by that?

A. Well, let me try and explain then. When I left the wards and went into these various different roles that I had undertaken up until the point of retirement, some of those roles, particularly the latter roles, would have been around trying to make the environments of the older wards better and more conducive to patients, you know, and I do use the word intentionally "living in them". And, yes, they certainly didn't lend themselves 15:06

to what one would class as typically a hospital ward where you can complete assessment and treatment and so on. The environments were awful. They were totally the wrong layouts. They were like rabbit holes. They made it extremely difficult, I believe, for staff to manage, because there was - again, for the want of a better word, so many cubby holes and so on in them. They were just not of a good environmental structure where, you know patients, I believe, would have had a better stay. 15:07

224 Q. Well sometimes the phrase "fit for purpose" is used, perhaps too often, but would you have considered them --

A. They were not fit for purpose.

CHAIRPERSON: And you're not just talking about Erne Ward? 15:07

A. No, no, there were other wards.

CHAIRPERSON: Can you name them?

A. Well, in my view certainly Erne and Ennis, which were two wards, if you like, under one roof, but they were almost a mirror image of each other. 15:07

CHAIRPERSON: Yeah.

A. There was - let me think now. One of my very, very first wards, Moylena, which was a young adult, young male adult ward, I certainly would have not claimed it as being fit for purpose. Ehm, Erne, Moylena. Ehm, I suppose there was also, in my time on the wards there were these pre-fab buildings, which have long disappeared many, many years ago. Again, I wouldn't 15:08

have said they were fit for purpose. Ehm, and then the other wards like Greennan, Rathmore, Rathmullan, they were essentially just big long buildings with large dormitories, a few side rooms, a staff room, an office. When you looked at what the new wards were going to offer and so on, these things were just so, so awful, and not fit for purpose.

PROFESSOR MURPHY: But you say in paragraph 18 that you were in charge of the capital expenditure.

A. Yeah.

PROFESSOR MURPHY: So could you not effect some changes in some of these terrible wards?

A. Absolutely. Yes, absolutely. And if you want me to come on to explain some more about that, I'm quite happy to do so at this point.

One of my roles was, as you quite rightly say, looking after capital expenditure, but it wasn't solely for Muckamore. When I was asked to take on the role it would have been for the Directorate, and when I say a Directorate, that was the Adult, Social and Primary Care Directorate. So how that worked at that time was that I think everybody would appreciate that we work with what's known as two pots of money; capital and revenue. Revenue being used for the day-to-day running. Capital for new, new works and so on. So certainly in terms of the older wards there were numerous - and I'm quite happy to use the term "numerous" - projects for which I secured funding and

which were completed within the wards to try and better the wards and try and better the environments. But when you have an old building which was never really built for the purpose that it was being used for, it's very difficult to achieve what you want to achieve without essentially taking the building down and re-starting. But, yes, there was a lot of capital expenditure put into those types of wards which I would have secured through the capital evaluation team. But as I say -- 15:10 15:11

PROFESSOR MURPHY: And how did you decide which buildings to spend it on? I mean, was there a system whereby, I don't know, Ward Sisters would come and say --

A. Absolutely. 15:11

PROFESSOR MURPHY: -- "I need my building painted", or whatever.

A. Absolutely. Yes, absolutely. You're almost summing it up for me. The issues as they arose would have been -- well, the issues would have been brought by the Ward Managers initially, they were obviously the frontline people who were experiencing the problems, and they would have brought that forward to the senior management team. That would have been their immediate line manager, and the hospital services manager, and so on and so on. There would have been a discussion within the hospital as to what was priority. Then we would have had to complete - and I would have helped the ward staff do this - complete what was known as a 15:11 15:11

mini business case for me to be able to take forward to the capital evaluation team. But bearing in mind of course, on top of that, that we're talking about funding for a directorate and not simply a hospital. So there were competing priorities and competing pressures. So it didn't mean, for example, that if I went forward and requested money, but another part of the directorate also had priorities, that the money always automatically went to Muckamore, and that was not how it worked and that was not the case. 15:12

PROFESSOR MURPHY: So it wasn't ringfenced for Muckamore?

A. Sorry?

PROFESSOR MURPHY: So it wasn't ringfenced for Muckamore in any way? 15:12

A. No, no, never. Never.

DR. MAXWELL: So presumably if you thought the state of a building was presenting such a risk, you could make a business case to the Trust corporately to say "The budget we have is to deal with maintenance, but we've actually got something here that is expensive and urgent"? 15:13

A. Yeah, that would most likely have been the way that it should have been done. That would not have been my call, that would not have been at my level, that would have been a case of the Ward Managers, the senior nurse managers, the hospital services managers and so on, taking that up the corporate route. 15:13

DR. MAXWELL: So you said earlier you would help the

Ward Managers to write a mini business case to be presented in the directorate to use the money that had been allocated to the budget.

A. Yeah. This was here and now money.

DR. MAXWELL: Yes. No, I understand. This is the money that's in your budget. 15:13

A. Yeah. Yeah.

DR. MAXWELL: And it's not enough to meet all the needs of everything in the directorate, so priorities have to be made. 15:14

A. Absolutely. Yeah, yeah.

DR. MAXWELL: So the responsibility for the estate didn't stay with you?

A. No.

DR. MAXWELL: If they came to you and said "Can you afford to do this", and you said "We have got the money for it", the responsibility for escalating that didn't lie with you, it lay with the Ward Manager? 15:14

A. And they would not necessarily have come to me, they would have went to their own managers, and it was their managers who would have come to me. 15:14

DR. MAXWELL: Yeah. But surely ultimately the responsibility lies with the Directorate? And what I'm wondering is who would be your senior in the Directorate level who is responsible for estates? 15:14

A. Well obviously there's a Director for the Directorate.

DR. MAXWELL: Yes.

A. And obviously issues were escalated up to her and so on. But, you know, ultimately at the end of the day it

comes down to you can only do so much.

DR. MAXWELL: No, I understand, but I'm just wondering where accountability goes. So there wasn't anybody else. There was you managing the estate?

A. No, no. No, no, sorry, sorry, I wasn't managing the estate. What I was doing, and I think I really want to be clear on this. 15:15

DR. MAXWELL: Okay.

A. I was not managing the estate, I was assisting wards where they believed they had issues that needed to be dealt with, I was assisting them to try and source funding to do that. Can I quote an example as such here? And I would be pretty sure that all of you are aware of it at this stage. Within some of the older wards where we had to create, and people have used all sorts of terminology for this, from "apartments" to "pods" and all of that, obviously it took funding to create those. 15:15

DR. MAXWELL: Yeah, yeah. Yeah.

A. And that's the type of thing. A second example would be in the new ward, so we want to take old and new, in one of the new wards where one of the large day spaces acoustically it was actually distressing for patients, and we wanted to do something to try and put in measures to reduce noise levels, and they approached me in respect of that and I had to go and look for funding for that. 15:16

DR. MAXWELL: So you weren't making the decisions about where to spend the money, you were helping the Ward

Managers --

A. Absolutely.

DR. MAXWELL: -- write the cases.

A. Absolutely.

DR. MAXWELL: Who was making the decision within the Directorate about whether to spend the available funds? 15:16

A. Ultimately I would have said that probably came down to the Director.

DR. MAXWELL: So it was the -- you were helping produce the cases about the estate? 15:16

A. Yeah, yeah.

DR. MAXWELL: The Director would decide "Can I afford it with my current budget?".

A. Yeah.

DR. MAXWELL: "Actually, if it's that serious I'm going to escalate it." 15:16

A. Well, not within current budget. Bear in mind this was capital money.

DR. MAXWELL: Yes, but normally a Directorate gets some capital allocation as well. 15:17

A. Yes, and it's normally allotted three times a year.

DR. MAXWELL: Yeah.

A. And what I'm trying to say to you is --

DR. MAXWELL: Yeah. No, this is additional cases --

A. -- I could have went to those CET meeting with we'll say 12/15 business cases and maybe got funding for two. 15:17

DR. MAXWELL: Yeah. Yeah. No, I understand. Thank you.

CHAIRPERSON: And I'm so sorry, it's my ignorance.

When you say "the Director", is that the Director for Disability Services? Which Director are you referring to?

A. Well, Adult Social and Primary Care is what I would have known it by.

CHAIRPERSON: Right. So that would be at the top of your tree, as it were?

A. Yeah, yeah.

CHAIRPERSON: So you didn't have the autonomy? You didn't have your own budget, as it were?

A. No, no, no. Definitely not, no.

CHAIRPERSON: And do you remember escalating these concerns to the Director?

A. It wasn't my role to escalate them in the various areas. You see I think we're trying to focus too much on Muckamore here in the sense that there were other areas within the Directorate, mental health, children services and so on.

CHAIRPERSON: Yeah.

A. I could -- it just would not have been possible for me to escalate all of these issues and so on. The services themselves would have had to escalate those issues.

CHAIRPERSON: And they would escalate them directly to the Director, not to you?

A. Well, I presume they would have went through their own line management until it got to the point of Director.

CHAIRPERSON: I'm still trying to work out what your role was.

A. Sorry?

CHAIRPERSON: I'm still trying to work out what your role was in all of this?

A. My role was, when it was agreed what was being done, I would have went and helped the service to write their business case.

CHAIRPERSON: Oh, I see. Okay.

A. And then go to the capital evaluation team meeting and make the case for "Look, this is top priority, this is second priority, this is third priority", and so on and so on. But as I have just said, if I was going armed with 12 business cases, the amount of funding that was available, because bear in mind you were -- this capital evaluation team meeting was for the whole of the Belfast Trust, not just one small aspect of it. 15:18 15:18 15:19

CHAIRPERSON: Yeah. Okay.

A. And I think everybody here can appreciate the amount of services that are within the Belfast Trust.

CHAIRPERSON: Does that exhaust that topic?

225 Q. MR. McEVOY: It does. There are two before I leave it. One, Mr. Ingram, I hope I heard you correctly, relates to when I asked the principal question there about the recollection of the other witness that we heard from yesterday about Erne, you mentioned a number of others among those, if I heard you correctly, was Ennis? 15:19 15:19

A. Erne and Ennis were two wards under the one roof.

226 Q. Yeah. Yes. And you listed it as being one of the others in which you, in general terms, agreed with that witness's account of the environment?

A. Absolutely. Yes.
227 Q. Thinking about Ennis, were you aware of the issues that arose on the Ennis Ward and the subsequent report? Were you cited on those?
A. No. No. 15:20
228 Q. Was anything within it shared with you as a member of management?
A. No. No.
229 Q. Okay. All right. And then just the other point before we perhaps leave the topic. The Panel are maybe trying 15:20 to locate your role within Muckamore. It was a point that I was intending to cover as you describe your various future roles as you went through your career in Muckamore. Have you retained your job descriptions by any chance? 15:20
A. Personally?
230 Q. Yes.
A. No. But I do know that towards the latter part of my career those would have been given to the PSNI.
231 Q. Right. Okay. You personally would have been provided 15:20 with one though, presumably?
A. Not for each one. Not for every one of the roles that I done. I'm not sure how it happened, but some of the roles just seem evolve and move on to the next one and so on. 15:21
232 Q. Yes.
A. But, yes, there were job descriptions for certainly at least two of them, and I remember as part of my role at that time having to gather information, not solely for

myself, but for other people within the hospital and so on, that the PSNI had requested, that those would have been handed over to them.

233 Q. Right. Well maybe then that takes us onto the next topic? 15:21

CHAIRPERSON: Yes. Okay. Shall we take a 15-minute break? Thank you very much. You'll be looked after. We'll be back in 15 minutes.

THE INQUIRY RESUMED AFTER A SHORT ADJOURNMENT AS FOLLOWS: 15:22

CHAIRPERSON: Thank you. I'm aware we've got quite a way to go. Are we starting at around paragraph 20? If we need to sit late, I'm afraid we'll have to sit late this evening. 15:37

234 Q. MR. McEVOY: Paragraph 20, as the Chair has indicated, Mr. Ingram, you're talking about the installation of CCTV within the hospital. Perhaps if we just look above at paragraph 19 before we move on, just to orientate ourselves properly in this topic. If we take up there, "A Core Hospital Group" and I think we've pretty much agreed that what you were saying was that a core hospital had been formed to see how we could try to manage incidents, which is the incidents of patient-on-patient and patient-on-staff abuse within the hospital and to reduce those incidents. You were a member of the group? 15:37 15:38

A. Ehm, I really would like to clarify this point here.

The Core Hospital Group was a group that existed within the hospital. I was invited to meetings of it when issues arose that pertained to what my role might have been at the time. So, for example --

235 Q. Sorry, pause there. Pause there. We just need to unpack that a wee bit. All right? 15:38

A. Okay.

236 Q. So there was a Core Hospital Group?

A. Yeah.

237 Q. You were not a regular attendee? 15:39

A. No, no.

238 Q. You were asked to attend or invited to attend as and when required?

A. Yes.

239 Q. Now, you then said where there were issues or topics relating to your role? 15:39

A. Mhm-mhm.

240 Q. Right. Can you try to list those for us so that we understand what the core hospital group's expectations of your contribution would be? 15:39

A. Well, obviously the main one was the CCTV.

241 Q. Could you speak up just a little?

A. I say obviously the main one was the CCTV.

242 Q. Yeah.

A. I can't -- I'm struggling to remember what other issues I was invited for. Because that one went on for so long I can't really remember. 15:39

DR. MAXWELL: Can I ask? Were you invited because at this time you were the business manager and you would

be helping to create a business case for CCTV?

A. Absolutely, yes.

DR. MAXWELL: So the Core Group, which had been running for some time, was concerned that there was an increase in these incidents, and the idea of CCTV had been discussed and you were brought in to think about a business case. Is that correct? 15:40

A. Yes. That's correct.

DR. MAXWELL: Thank you.

CHAIRPERSON: Right. Thank you. 15:40

243 Q. MR. McEVOY: And you worked alongside -- on the group you worked alongside H730, Co-Director; Eilish Steele, who was the Service Manager.

A. Yes,.

244 Q. H287 and H77, and a social worker, the name of whom you can't recall. The group met over a two year period when it was decided that the hospital should install CCTV. And you recall initially it was to be trialed in one area of the hospital? 15:40

A. Yeah. 15:40

245 Q. The business manager's role evolved over time and began to take on different responsibilities, one of which became the installation of CCTV within the hospital. So the business manager's role, which is to say your role, is that right? 15:41

A. Yeah.

DR. MAXWELL: Sorry, just before we get to that. So at the Core Hospital Group it was agreed to write a business case for CCTV, and then you oversaw the

writing of the business case.

A. Yeah.

DR. MAXWELL: Who was the business case presented to? Did that go to the Capital Committee that you described before? 15:41

A. Ehm, initially when it was completed it would have been presented back to that core hospital team.

DR. MAXWELL: Yes.

A. And then as I understand it, it would have been escalated up through Co-Director level, Director level, 15:41 and so on. And, yes, eventually then would have been taken.

DR. MAXWELL: But there are delegated spending limits, aren't there? And we've heard from other witnesses that this didn't reach the threshold to go to the 15:41 Trust-wide Capital Committee. Do you know which committee approved it?

A. It went to the Trust Capital.

DR. MAXWELL: You think -- you are clear it went to the Trust Capital? 15:42

A. Well, no, I don't think, I'm absolutely sure.

DR. MAXWELL: No. You know.

A. Yes.

DR. MAXWELL: So the Corporate Capital Committee for the whole of the Trust... 15:42

A. Yes.

DR. MAXWELL: Considered this business case.

A. Absolutely.

DR. MAXWELL: And approved it.

A. Yes.

DR. MAXWELL: So it had been approved. The funding was approved and then it came back down, and you were asked to take responsibility for enacting this, purchasing it, and installing it. 15:42

A. Absolutely. Absolutely.

DR. MAXWELL: Okay. Thank you.

246 Q. MR. McEVOY: The group's -- just going back up to your description of the group. It's remit, in terms of your description, was to see how you could manage these 15:42 incidents and reduce the number of incidents. Apart from the proposal to trial CCTV, were other strategies or options discussed?

A. Ehm, I can answer that quite easily. I undoubtedly believe that there were, and they would have been 15:43 discussed at that particular group meeting, but I wasn't a member of that group.

247 Q. Right.

A. I was only, as I said earlier, invited in for this one strand of it. 15:43

248 Q. Which was the?

A. The CCTV.

249 Q. And what particular then, what particular strand, or was there a particular strand that initially brought you in? What aspect of the CCTV initially brought you 15:43 in?

A. When that group had reached the point of agreeing that we would trial CCTV in one ward.

250 Q. Okay. So the decision to trial CCTV was taken before

you --

A. Yes. Yes.

251 Q. -- began attending?

A. Yes, yes. Absolutely.

252 Q. Is that correct? 15:43

A. Yes.

253 Q. All right.

A. Yeah.

254 Q. You took on different responsibilities. I was just about to put to you one of which became the 15:43 installation of the CCTV in Muckamore. What other responsibilities did you have? And I'm not sort of intending that you provide us with an itemised list, but what were your general --

A. I would struggle with that and I really would have to 15:44 have my job description in front of me to...

255 Q. Yes.

A. Because I just genuinely would struggle. I really would need access to a copy of the job description for that. 15:44

256 Q. Yes. So as this time, the post, which is to say that of business manager, became a Band 8B post and you had to interview for it, and you recall something of your interview?

A. Yeah. 15:44

257 Q. You were responsible for procuring and sourcing the funding for the installation of the CCTV system, and you had to carry out a lot of research to see the impact of CCTV installation in other hospitals in

Ireland and in England. Now, tell us more. Can you give us, I suppose, a headline explanation of the process of commissioning essentially of the CCTV?

A. Of?

258 Q. Commissioning the CCTV? 15:45

A. I'm not entirely sure I understand.

259 Q. All right.

A. At what point do you want me to...

260 Q. Well, tell us about how -- what were the initial steps that were taken and who was involved in the decision to 15:45 install the CCTV? How did you go about it?

A. Well, as I said a moment ago, the final agreement, if you like, to proceed with the installation of CCTV, it's inception was at that Core Hospital Group.

261 Q. Yeah. Yeah. 15:45

A. And as I've said, it would have went up through the various line management routes to...

262 Q. Yes.

A. -- I certainly imagine Director level. I'm not sure if she took that above that or not. 15:46

263 Q. So it has been green lit, I suppose, for want of a better phrase?

A. Yes. Yes. Yeah.

264 Q. And now you're coming in to help take it forward?

A. Absolutely. 15:46

265 Q. Right. What's the first thing that happened?

A. Ehm, well because agreement had been reached then, that we were going to, as you quite rightly say, go green with it. This was a totally unprecedented thing for

the hospital.

266 Q. Yeah.

A. Never had anything like this here ever been undertaken. And obviously I was tasked then as to how is all going to work? 15:46

267 Q. Yeah.

A. So I suppose my initial steps was, well, has it been done anywhere else? How did they go about it? What were the steps involved? And when I say I researched this, this is what I mean by research. 15:46

268 Q. Mhm-mhm. Did you carry that -- was there a working group within this Core Hospital Group or was it left to you alone?

A. Well, there certainly -- I wouldn't have classed it as a working group, but there was certainly myself and one other person who, H77, who would have looked very much at this. 15:47

269 Q. So just the two of you?

A. Yeah. Yeah. Now, there did become a working group when it moved on in time to things like the policy for implementation and so on. 15:47

270 Q. Right.

A. But certainly in the initial stages - and that's when I refer to research and so on, what was happening elsewhere? How had they done it? What steps had they taken? What was the impacts of it? What was the good points, the bad points? And unfortunately there was nothing within Northern Ireland that we could find at that time that you could physically go and see, but I 15:47

think throughout the time that we were putting it together it came into one other facility. I don't want to name the facility because I'm not 100% sure.

271 Q. That's okay. That's okay.

A. I do know it came into one other facility, but I'm not 100% sure about the name and I don't want to give out a wrong name. So we did have an opportunity to have look at that in that facility, and then I suppose it was gathering that information all together, coming back and presenting it to various different groups really, it wasn't just to one sole group. 15:48

272 Q. When you say not just one sole group, you mean not just the Core Group?

A. Exactly. Exactly.

273 Q. Right. 15:48

A. Because obviously, you know, once we had that type of information gathered and so on, we certainly did come back and present to them, but there was wider groups of people who needed to know and understand what this was all about. 15:48

274 Q. Yeah.

A. And what was going to be the benefits of it. What was -- well, I suppose --

275 Q. Are you beginning to describe what we might understand as a process of consultation? 15:48

A. Yes. Yes.

276 Q. Or is this something else?

A. No, no, no, consultation. Yes.

277 Q. Right. And is this a process of consultation with on

the one hand staff members?

A. Absolutely.

278 Q. And what about relatives?

A. We would have consulted with -- the first and foremost people were the patients. 15:49

279 Q. Yeah.

A. That's always first call.

280 Q. That was done?

A. Absolutely, yes.

281 Q. Okay. 15:49

A. And that would have been done through the patient focus groups that were within the hospital.

282 Q. And how did you -- what practical steps did you take to ensure that the patients understood what was being proposed? 15:49

A. Well, the focus groups that were established at that time were involved in lots of issues that were going on around the hospital.

283 Q. Yeah. Let's just concentrate on the CCTV though? So you had -- 15:49

A. Yeah, yeah. No, but the point I'm leading on to is, the management team would have thought that they could understand, if you like, what we were talking about and so on.

284 Q. Yeah. Yes. 15:50

A. And that's why we would have met with them particularly. So that they, you know, we would have been pretty confident that they would understand what it was that we were explaining to them.

285 Q. Well, you say "pretty confident", I mean this is a proposal to install CCTV in the place where they live?

A. Yeah.

286 Q. Wouldn't you have needed to have been more than pretty confident that they understood? 15:50

A. The meetings, as they occurred, time was provided at the end of each meeting for any questions to be raised, anything that wasn't understood. If I remember rightly there were - I just can't remember their title now - but people who were almost patient advocates. 15:50

287 Q. Yeah.

A. Would have come along with the patients to those meetings and they would have assisted the patients in terms of asking questions or seeking clarification or whatever. So we weren't solely leaving it to the 15:51 extent that we hoped patients understood it, we were doing everything that we could to make sure that they understood it?

288 Q. Did you produce any form, or do you recall whether any form of document or leaflet, explanatory leaflet was 15:51 prepared for the benefit of the patients, perhaps in and Easyread or some other form?

A. Yeah. I don't honestly recall anything.

289 Q. All right. So the patients were consulted with first. Is that correct? 15:51

A. Yeah.

290 Q. And who was consulted with after that then?

A. Staff.

291 Q. Okay.

A. Families. Ehm, if I remember rightly I think some of the other Trusts were consulted with as well.

292 Q. Yeah.

A. Because obviously, I don't know if -- well at this stage I'm sure you all do understand that the patients in Muckamore weren't just simply Belfast Trust patients. 15:52

293 Q. No, of course.

A. They were patients from other Trusts and so on. So obviously there was an impact for them as well. 15:52

294 Q. Yeah.

A. And they had to be made aware of what the proposal was and what we were talking about and so on. I don't believe I was involved in those discussions, I certainly have no recollection of being involved, but I do believe that those happened. 15:52

295 Q. Okay. So you were involved in the discussions with patients?

A. Patients, staff, and families.

296 Q. Families. All right. And in addition to you, was H77 involved? 15:52

A. Yes.

297 Q. Had you any other help or input from any other management?

A. Yes. H290. 15:52

298 Q. All right. Okay. And do you know whether -- I asked you about the provision of information in some kind of written form, but do you know whether your consultation meetings were minuted? Did either yourself, or H77, or

290 take a note just to record?
A. Yes, I do recall this, and there were notes.
299 Q. Okay.
A. Yes.
300 Q. And do you recall who made them? 15:53
A. Any one of the three of us.
301 Q. All right.
A. Depending on who --
302 Q. You may have made notes yourself?
A. I definitely recollect myself making notes, yeah. 15:53
303 Q. And have you retained those notes?
A. Eh, not personally.
304 Q. Yes.
A. I haven't retained any property whatsoever belonging to either the hospital or the Trust. 15:53
305 Q. That's okay. So this was an initial meeting then to talk about the proposal that CCTV be installed, and was the same level and degree of information, obviously allowing for the patients with learning disabilities, was the same degree of information about the key facts 15:54 conveyed to each?
A. Absolutely. And that's coincidental, I think, you actually raise that question, because that was one thing that we were conscious of prior to doing any of this consultation, that the same messages needed to be 15:54 delivered to everybody.
306 Q. Yeah.
A. So that we weren't in a situation where we were given mixed messages. So, yes, that's absolutely. Yeah.

307 Q. And thinking back then, I suppose if we take each in turn, do you recall there being any, any querying or uncertainty from the patients about the proposal?

A. Yes, absolutely. Some were for, some were against. They would have provided their own reasons and rationales either for being against it or being in favour of it. I obviously don't recall all those reasons at the moment. It certainly would have involved things like "Well, that's going to be an invasion of our privacy", and so on, you know the typical type responses. 15:54 15:55

308 Q. And obviously very important ones I'm sure?

A. Oh, absolutely. Yeah, yeah. No, no, absolutely. But not surprisingly there were also those who were in favour, patient-wise, which was a different - sorry, a slightly different scenario then when it came to staff, because when we held the consultations with staff I think I can safely say 99% were in favour. 15:55

309 Q. In favour of it?

A. In favour of it. Yeah. I do remember that quite clearly. 15:55

310 Q. And what about then -- finally, but no less importantly, what about relatives and family members?

A. The families. Again, I think from memory, the sort of higher percentage of relatives that we would have consulted with were in favour of it. 15:56

311 Q. Yep. In your witness statement at the top of page 9, that's in paragraph 20, it's the next page from where we are, can I just ask you, without wishing to engage

in semantics, this phrase is used, you told us a moment or two ago that 99% of the staff were in favour of the CCTV. You've said in your statement here:

"The staff were not negative towards the idea of installing CCTV." 15:56

I suppose one might think it peculiar that you haven't said the staff were overwhelmingly in favour, or entirely or overwhelmingly positive about the idea of installing CCTV. You've gone for "not negative"? 15:56

A. Yes, and I apologise for that, perhaps my statement should have read along the lines of "the majority of staff".

312 Q. All right. You have mentioned that you consulted with families and you say other relevant stakeholders. You haven't, in the body of your statement, specifically identified patients there. Is there a reason why? 15:57

A. I haven't identified?

313 Q. You haven't specifically identified the patients? 15:57

A. And, funny, when I read over the statement myself, it's purely an oversight.

314 Q. All right.

A. They should have been in there.

315 Q. The initial concept was that the CCTV footage would only be reviewed when an incident was reported, so that a recording of the reported incident could be viewed and to clarify what had happened. So I suppose is the Inquiry to take it then that that was the understanding 15:57

of yourselves and of the relevant or the various stakeholders --

A. That was certainly the message that we were delivering.

316 Q. Okay. So in paragraph 21 then you tell us that:

15:57

"Once the CCTV went live, a member of staff, I cannot recall who this was, reported that they had witnessed a staff-on-patient incident whereby it was alleged that a member of staff had hit out at a patient on the PICU Ward."

15:58

And then you say that you were asked by H507, Service Manager, to look at the CCTV footage to ascertain if the incident was recorded. And you found that it was. Was that a surprise?

15:58

A. That it was recorded?

317 Q. Yes?

A. I would say it wasn't a surprise, it was an absolute shock!

318 Q. Mhm-mhm. And why was it an absolute shock?

15:58

A. Ehm, I suppose up until that point, for me, personally, and again, as I say, I can only speak personally.

319 Q. Of course.

A. I would not have believed that that type of thing was occurring,

15:58

320 Q. Mhm-mhm. And other than what was actually contained on the clip, was there anything else about the very fact of there being a recording at all that was a shock or a surprise to you?

A. Yes. I suppose just to give a bit of context to this. When - and you'll forgive me, I can't remember exact times and dates and months and so on here.

321 Q. That's okay, just do your best.

A. But I can certainly set the context for it. When the CCTV was initially implemented in the ward that had been agreed, there was a period of time between it having been installed and implemented, until the point where we officially saying we were going live. And what had occurred at that point was, we shouldn't have been able to locate that incident because it should not have been there, but yet it was. 15:59 15:59

322 Q. Mhm-mhm.

A. And some time prior to that we had ascertained that the system was running, running live. And that came about really because the engineers who installed the CCTV were in doing some maintenance, and I suppose final checks and so on for the system going live on the date that we had agreed to go live, and on the day that they were there doing that I was actually speaking to the engineers, pretty much on an informal basis, and they had been there quite some time, I had gotten to know some of them because I would have had to sign off their service sheets and so on for having been on-site. And I was saying "Oh, this will be great, you know, once we get it up and running", and so on and so on, and that's when I was made aware the system was actually running live at that point. I personally wasn't aware it was running. None of the hospital management team were 16:00 16:00 16:01

aware that it was running. Ehm, so as soon as I became aware of that fact, I made that known to H507, and she then also made it known to H287, and as I understand it, and I'm trying to recollect my very best how this all panned out then after that, they made that known to 16:01
I think both the Co-Director and the Director and so on, I'm not sure how far up the management line it went, but it certainly did I think go up as far as Director level. Ehm, so, I'm not sure what happened thereafter, but we did have to go out and explain to 16:02
staff, and families, and patients "Look, there's been an error here. The system has been running for a period of time prior to us telling you that it was going live", there absolutely had been an error, there's no doubt about that. One of the things that I 16:02
was asked to do at that time was to establish why this had gone wrong and why was it recording when it shouldn't have been recording? So obviously the answer to that lay in speaking to the contractor.

323 Q. Yep. 16:03

A. So I had a meeting with the contractor, and obviously at that time with any type of work like that there, and so on, our on-site estates colleagues were very much involved as well, in terms of work permits and different things, you know, providing these contractors 16:03
with work permits and so on, and we met with the - I don't know what position he held in the company, but he was the person that we had dealt with all along - and we had the initial meeting, we told him what had

happened. Obviously he needed a period of time to go off and find out then what had happened as well. I'm not sure how long after it happened, but we came back together again to discuss "Well, what's the findings here? Why has this happened?", and I can only be as honest as I can be here and say that it appeared to be a genuine misunderstanding, in that the contractor had said to us -- there was no clear either written or verbal instruction to the contractor to switch it off after they had provided training to ourselves. 16:03 16:04

324 Q. Yes.

A. Neither so was there any clear verbal or written confirmation that we had told them to switch it off. So, in essence, when they came back to explain to us what had happened was, they said in the absence of that instruction, and so on, but equally as part of the contract that we had with them, it had been left running so that they could establish that the system itself would hold the capacity of footage that they were claiming that it would hold. I can't honestly off the top of my head remember what that capacity was. There's something in the back of my head says 90 days, but please don't quote me on that, I could be totally wrong. 16:04 16:05

The system, once it reached the point of whatever the capacity was, there was no such thing as backup tapes or anything with this, it automatically began to overwrite itself. 16:05

CHAIRPERSON: So did you discover how long it had been working when nobody realised? How long had it been going for?

A. We did at that time, and I'm struggling to remember, but it was, it was months anyway, you know. It wasn't days or weeks, it was months. 16:05

CHAIRPERSON: Right. Okay.

325 Q. MR. McEVOY: So that we understand, I know this is perhaps just taking it very piece by piece, but we just want to understand the chronology of events, I suppose, as best we can. You were -- there was a report by a staff member that they had witnessed a staff-on-patient incident. 16:06

A. Yeah.

326 Q. Was this advised to you by H507? How did you come by that initial piece of information that this report had been made? 16:06

A. Yes. H507.

327 Q. She asks you to look at the CCTV footage to ascertain if it was recorded. Now can we understand better what the thinking was about that? Was this maybe by some marvellous chance the recording equipment was on and it's been picked up, or was she asking you completely unaware of whether or not it would have been switched on? What did you understand your -- 16:06 16:07

A. No, no, at the point, at the point where she had asked me to go and look to see had this particular incident been captured, we knew that the system was live.

328 Q. You knew. Yes. Okay.

A. We knew the system was live.

329 Q. So everybody -- so nobody was in any doubt at the point in time when the report came in that the CCTV --

A. No, no. No.

330 Q. Okay. So there's no doubt about that? 16:07

A. No. None. None.

331 Q. So how was it then that you realised that there was, I suppose, far more footage than there ought to have been? How did that realisation come about?

A. It's difficult to explain unless you're physically 16:07 sitting in front of the system to see how it operates, and so on.

332 Q. Yeah.

A. But it operates very much like, can I say this, you know, you have your rewind, your fast forward, your 16:07 pause, your stop, very much like the old music centres and systems and so on.

333 Q. Yeah.

A. Pretty much similar to that there. So in terms of looking for the date that we were looking for - because 16:08 bear in mind of course that it was still pretty new, especially to me at this stage - I had put it in rewind, had put it at a high speed, it went much further back beyond the date that I was actually looking for. I actually had to get it slowed a way 16:08 down and take it, you know, forward quite slowly to get to the date where I was looking for. And that was the point, that's the exact point when I realised there is more on this than what we're solely looking for, for

that one incident.

334 Q. So it was the function, it was kind of the high speed rewind?

A. Absolutely.

335 Q. Is that correct? 16:08

A. Absolutely. Yeah.

336 Q. Right. Okay. Okay. And having being faced with this realisation, what was the first thing that you did?

A. That there was other CCTV?

337 Q. Yes. 16:09

A. Was speak to, sorry, H507.

338 Q. All right. And you presumably advised her of this?

A. Absolutely.

339 Q. Okay.

A. Well, sorry, advised her and, and H287. 16:09

340 Q. Okay. You advised them both together?

A. I can't remember if they were together, but I certainly advised them.

341 Q. Okay. Was it verbal or was it an e-mail?

A. Verbal. 16:09

342 Q. Okay. You don't remember whether it was, whether they were together when you told them this?

A. I don't honestly remember, no. But I do remember I certainly spoke to both of them.

343 Q. Okay. 16:09

PROFESSOR MURPHY: Can I ask you - sorry to interrupt, Mark - was the CCTV policy all signed, sealed and settled at that stage? Because we understood from various witnesses that it took a very long time to be

written?

A. As far as I remember it was signed, sealed and delivered, and you're absolutely correct when you say it took a mammoth amount of time to get the policy to the point of being signed, sealed and signed off. You're quite right when you say that. 16:10

PROFESSOR MURPHY: Who was developing the policy?

A. Well, I was involved in that as well, and there were a number of us. I can certainly quote H77 as being involved. There were a number of other staff and, again I apologise, but I would need to have access to my prior, my own prior -- 16:10

PROFESSOR MURPHY: So you were involved in discussing it, but you weren't leading it?

A. Ehm, I don't know that I was leading it, I was certainly part of the group who were gathering views and so on from the various different groups that were involved in signing it off and so on. 16:10

CHAIRPERSON: I mean I think we've heard that it took approximately two years to sort this policy out. How conceivably could it take that long? 16:11

A. Well, undoubtedly I believe it took that length of time. The policy, because this was such an unprecedented thing to happen within the hospital, the introduction of CCTV. 16:11

CHAIRPERSON: Yeah.

A. And there was so many different people to consult with, agree with, we had to be absolutely sure what we were putting into it was legal, viable.

CHAIRPERSON: Right. Okay.

A. And then in the end it had to go through an equality impact assessment, and that took ages and ages.

CHAIRPERSON: Okay. But by this point, which is -- are we in August '17 now? 16:12

A. Yes.

CHAIRPERSON: Yeah. But by August '17 the policy had been signed off?

A. As far as I remember, yes.

CHAIRPERSON: Right. Okay. 16:12

DR. MAXWELL: We've got copy of it. It was signed off in June.

CHAIRPERSON: You're right. You're right. Thank you. Well I said by August.

DR. MAXWELL: We've seen a copy and it was signed off in June. 16:12

A. Oh, was it June?

CHAIRPERSON: Okay. So let's move forward.

344 Q. MR. McEVOY: Perhaps just before we leave that particular point about the policy, you told us a little bit earlier in your evidence that you had looked at other institutions where CCTV had been installed in Great Britain and in the Republic of Ireland, did it occur to yourself or to H77 to look to those other institutions for their policy, as least as a precedent? 16:12 16:13

A. Absolutely, yes. Yeah.

345 Q. And did it offer any help?

A. It certainly did. It was of great assistance.

346 Q. Yeah.

A. Yeah.

347 Q. And did that, shall we say template or precedent of a policy, meet resistance then in terms of the agreement process within the hospital?

A. Sorry, I'm not sure I understand. 16:13

348 Q. So you had the assistance of examples from other institutions, is that right?

A. Yeah. Yeah.

349 Q. You did?

A. Yeah. Yeah. 16:13

350 Q. And they presumably gave you some basis to work off?

A. Yes. Absolutely.

351 Q. Is the time delay of over two years, is that explained by what? Is that explained by resistance from the Core Group in the hospital? 16:13

A. No, no. No, no, no, no. It's not - it certainly wasn't resistance. I wouldn't use that term whatsoever. It was just really fine tuning it. It really was fine tuning it. But the thing about -- and I think it's fair to say, certainly within the Trust, 16:14 you know, it would never take two years to get a policy past through.

352 Q. Yes.

A. This one, because I don't believe it ever existed anywhere else within the Trust, because it was such a 16:14 unique policy, and there were so many different people involved in it, and it had to go from one group, to another group, to another group, and sometimes I believe the delay was that it was sat on. Now, I don't

know if that was intentional or not intentional, I can't vouch for that,

353 Q. Mhm-mhm. I suppose that could be interpreted as a form of resistance?

DR. MAXWELL: But it had to be approved at various levels of the Trust. 16:14

A. It had to be approved.

DR. MAXWELL: So it wasn't just going round the hospital, was it?

A. Oh, no, no. No, no, absolutely not. 16:14

DR. MAXWELL: It was going right up to the top of the Trust.

A. Absolutely. Yeah, yeah. Yeah, yeah. Absolutely.

DR. MAXWELL: And there were delays at various committees. 16:14

A. Yes. Yeah, yeah. I think that's fair.

CHAIRPERSON: I think we've got to move forward...

354 Q. MR. McEVOY: So in terms then of your discussions with H287 and H507 about what you had discovered, can you help us then just to fill in the blanks in terms of 16:15 where the decision was made just to clarify the position with the contractors and the engineers about the start date? Like did you do that of your own initiative or were you directed to do that?

A. No, I was directed to do that. 16:15

355 Q. Okay. And can you tell us by whom?

A. Ehm, I would be guessing I think at this stage. I think it may have been an outcome of a meeting.

356 Q. Okay.

A. Where, you know, there was a general discussion about, you know, "Why has this gone wrong? How has this happened?", and so on, and "What are we going do here to fix this?", and I think that may have been one of the outcomes of a meeting. 16:15

357 Q. Okay. Okay. So we know then from paragraph 22 that a number of other incidents were reported, and you were asked to check and see then if the incident was recorded on the CCTV. Was this happening on an ad hoc basis? Was this someone else's -- in other words, were 16:16 you being told "We've heard about this report involving ex staff member and Y patient. Can you check that for us?", was it as ad hoc as that?

A. Yes. That's exactly how it occurred, yeah.

358 Q. All right. Was there no appreciation then between, and 16:16 this isn't a criticism of you, but was there no appreciation between yourself, H77, H507, or anyone involved, that maybe we ought to put a procedure in place here because there are a lot of these coming forward? 16:16

A. But a procedure did go into place then.

359 Q. Yes, it did. But at what point? I mean you're describing an ad hoc series of --

A. Yes, in the initial stages.

360 Q. Yes. 16:16

A. Yes, yes.

361 Q. All right.

A. It would have been ad hoc. Until I suppose there was that realisation that you're referring to "Hang on,

this is just too much here."

362 Q. I mean what you go and describe, and this is no criticism of you, I'm just reflecting back what's in your statement.

A. Yeah. No, no. Yeah. Yeah. 16:17

363 Q.

"Each time I checked the relevant camera for the time of the incident, if the incident had been recorded, showed the clip to a member of senior management, usually 507. If the incident was staff-on-patient the 16:17 police became involved. I assume this was the adult safeguarding team who informed them, having been advised of the incident by the senior management to whom I had shown the clip."

16:17

So pausing there. I mean what you have is a description of what I've called an ad hoc way of doing things, there's no -- it's quite, to use a word we used earlier on "informal", would you agree?

A. Mhm-mhm. I would totally agree. 16:17

364 Q. Yeah.

A. Yeah.

DR. MAXWELL: But wasn't this the procedure that had been agreed in the policy that had been signed off in June, that it would only be looked at if a concern had 16:17 been raised.

A. That certainly was contained within the policy. I think what was happening was that we were probably still within the boundaries of the policy in the sense

that "Hang on, an incident has been reported here. Let's go view it", but I suppose the point that I'm really trying to get across is the volume then that had started to occur.

DR. MAXWELL: Yeah. Okay. But at that point you were following the policy? 16:18

A. Yeah, yeah.

DR. MAXWELL: Rather than it being ad hoc.

A. Yeah. Well, yes, if you look at it that way, yeah.

DR. MAXWELL: Okay. 16:18

365 Q. MR. McEVOY: And in terms then of the direction to you to show the clip, was there anybody else involved, apart from 507, to whom you would have showed the clip?

A. Ehm, interesting point. In terms of the very initial incident, the very first one back in August. 16:19

366 Q. Yeah.

A. There were a significant number of people who would have - who I would have had to show it to.

367 Q. Mhm-mhm.

A. And that obviously involved initially 507 and 287, but because this was noted and so on, and I suppose it was the first incident captured by CCTV, there were numerous people thereafter who wanted to view this, or I was asked, sorry, to show to, and that was right up through our own Trust, to members of the other Trust, to members of the Board. I can't honestly remember if it went right to the department or not, but I've a sneaking suspicion that somewhere in the back of my head it tells me that it did. Ehm, and we would have 16:19 16:19

had a number of different people visit the hospital to specifically see this ones incident.

368 Q. Now, we're told also then that police would attend the hospital and it was your responsibility then to show them the footage? 16:20

A. Yeah.

369 Q. In the same way that you were showing it to those others, is that --

A. Absolutely. Yeah.

370 Q. Okay. And: 16:20

"If the police needed copies of the footage I would provide copies for the police to take away with them."

Can you just help us understand there the method the media -- 16:20

A. Yeah, yeah, sure. Absolutely.

371 Q. DVD or --

A. Yeah. What would have happened was you would have took a segment of the video, or of the CCTV, sorry, to where nothing was happening, the incident occurs, and a period of time thereafter. 16:20

372 Q. And who decided that? Who decided how long that should be?

A. I can't honestly remember, but I think we would have went something like 15 minutes either side of the physical incident occurring, because you know -- 16:21

373 Q. Sorry to interrupt, just it's an important point, but do you know whether that decision around 15 minutes

before and after, did that decision come from the Trust, or was it at the request of the police? Or maybe you don't know?

A. I honestly can't remember. I don't know. No, sorry, I don't know. So, sorry, to finish how we did this. So the system, the system hardware allowed for the download of footage, and that would have been downloaded on to CD-ROMs and, you know, we had to understand, "Well, look, how much can a CD-ROM hold here?", and be sure that we weren't, you know -- my concerns, and this was all part of learning for me, was that you made sure you got the right amount on to it, and if you had to go to a second CD-ROM, that you done that, that you captured all of what needed to be handed over to the police. 16:21 16:22 16:22

CHAIRPERSON: Sorry, I just want to understand. The original storage is actually on the hard drive?

A. The original storage is on the hard drive.

CHAIRPERSON: Right. Then if you want a copy extracted, you use a CD-ROM? 16:22

A. Absolutely.

CHAIRPERSON: Right.

A. Yeah.

374 Q. MR. McEVOY: Had you any technical or other kind of IT assistance with this process, was it left to you? 16:22

A. In one of my former roles I would have been an IT manager. Now I say that lightly in the sense that for the site, for the Muckamore site, part of one of my roles as business manager would have been where

equipment was required, for example, I would have been responsible for the, through the IT Department, procuring that and getting it on-site, getting it installed, getting it implemented, and so on and so on. So I had some IT expertise, but we had training from the company that installed the system.

375 Q. Okay. And did you call upon them to give you any assistance or help with the --

A. At the time of download?

376 Q. Yeah. 16:23

A. Yes.

377 Q. Okay. And were they prepared to help?

A. Absolutely.

378 Q. Okay.

A. Yeah, had no issues with them whatsoever. 16:23

379 Q. Okay. Now you then go on at paragraph 23 to tell us that the number of reported incidents to be reviewed for recorded footage was increasing at a fast pace, the number of incidents being reported was occurring on a daily basis, and you were advised by H507 that a 16:23 decision had been taken jointly by the Department of Health and the Belfast Trust to review 25% of the entire CCTV footage. Did H507 explain where the figure of 25% had come from?

A. Sorry, which H? 16:24

380 Q. H507.

A. Oh, sorry. Yeah, yeah.

381 Q. So I'm just four or five lines down in paragraph 23?

A. Yeah. I think I was simply told by H507.

382 Q. Okay.
A. I wasn't obviously at the meeting where this was agreed or whatever, do you know what I mean, those were much higher level meetings which would have been held up at headquarters in Belfast. 16:24
383 Q. Yeah. Okay. Now you then say, you go on to talk about the meetings of the Core Group Hospital when you were in attendance where there was discussion around what was going to be looked at, dates, what cameras, the time period, and so on, and then also who would conduct 16:25
the review of the CCTV. There was a focus initially on day-time hours, and that's a decision of the group. This was on the basis that there was likely to be more activity on the wards during the day than at night-time. 16:25
A. Mmm.
384 Q. You were asked I think in the statement making process whether or not you recall anyone, yourself or anyone else saying that there would be no incidents at night. You don't recall that being said? 16:25
A. Absolutely not.
385 Q. Do you recall a decision being taken to rule out looking at night-time footage?
A. Absolutely not, to my recollection.
386 Q. Okay. Now, I suppose the last main topic then is 16:25
really around the question of the viewing process for the CCTV.
A. Mhm-mhm.
387 Q. And it might be helpful --

PROFESSOR MURPHY: Before you go on to that can I just ask, how exactly did the Core Hospital Group decide on the 25% sample? Was it totally random or did they decide, you know, particular times or particular places.

A. Well, first of all, it wasn't simply just the Core Hospital Group. I think that was done in conjunction with the Department of Health, but would have involved other people, you know, Co-Director, Director, or whatever. It wasn't simply those people named as the Core Hospital Group that we referred to early on this afternoon. But in terms of the 25% itself, it was purely random over a period of time.

PROFESSOR MURPHY: Okay. Thank you.

A. So it would have involved mornings, afternoons, evenings, nights, weekends, whatever.

388 Q. MR. McEVOY: Okay. Sorry, I was just going to ask you then about the process of review.

A. Yeah. Yeah. Surely. Yeah.

389 Q. And at 24 then you talk about how these tended to be, mainly to be retired social workers working on ad hoc basis, and indeed the Inquiry has heard from some of them.

"I don't know how these viewers were recruited..."

- you say, but you believe that they came from a variety of Trusts, not only the Belfast Trust. Your role within the process then was to manage the review

of the CCTV footage by the viewers, and you didn't review it yourself?

A. No. No.

390 Q. You trained them on how to use the reviewing equipment and gave them an induction. Can you just help us understand a little bit about the practicalities? What sort of facilities were made available and used for this process? 16:27

A. Yeah, yeah, absolutely, and I can be quite clear about this. The actual hardware was located in a room in the main administration building. 16:27

391 Q. Yeah.

A. And that's where anybody who was viewing the CCTV would go to. We made it a secure room with additional locks and so on like that. So that's actually where the hardware was contained. In terms of what did it involve? It involved showing them the mechanics, if you like, of how to use the system. It involved -- I suppose I'm referring to the induction here, what were they told in their induction? And, again, there was clearly documented induction for each of these viewers, and I do believe from memory that a copy of that again was supplied to the PSNI. 16:28 16:28

392 Q. Okay.

A. I, for the greater part I think, was the person who would have completed the inductions with all of these external viewers. Ehm, I don't obviously remember everything that was on the induction sheet, but I certainly would have went through things like, you 16:28

know, probably one of the most important things on it was, you know, the confidentiality of all of this, because they may not necessarily have been Trust employees. In fact if I remember back rightly, most of these were retired people. 16:29

393 Q. Yeah. We just touched on that.

A. Yeah.

394 Q. Yeah.

A. They were retired people. So it was things like confidentiality, mechanics of the system, explaining 16:29 the schedule of viewing. The recording of what they were viewing, both in terms -- because while we were doing this, what we wanted to do was to pick up obviously where there was bad practice or allegations of abuse, but we equally wanted to pick up if there was 16:29 good practice that could be shared, and so on, and I do specifically remember that being discussed and so on, that, you know, at a point in time, possibly when this was all over, CCTV could become one of those tools, for the want of better words, to be used for learning 16:30 purposes.

395 Q. Did you have a role in batching the footage to be looked at? In other words, was there a decision about whether or not the material should be looked at chronologically, or camera by camera, or was there some 16:30 thinking behind how the material should be presented to the viewers? That's the first part of the question.

A. Chronologically.

396 Q. The second part of the question is, if there was, was

that explained to the viewers?

A. Yeah. Well, to answer the first part of your question, chronologically was the way that it was done.

397 Q. Right.

A. And by doing it chronologically we were going back. There was specific reason for doing it chronologically, and if I can just very quickly explain that to you? Because the system only has certain capacity before it begins to overwrite itself, you want to go back to the earliest part first. 16:30 16:31

398 Q. Yes.

A. So as you're not losing, or you're trying to minimise the amount of loss. So that was the rationale for having it chronologically. In terms of the slotting of it, I think was the word you used. 16:31

399 Q. The batching?

A. Oh, batching, sorry.

400 Q. It was just the term to kind of describe how it was prepared and put forward for viewing.

A. Yes. Yes. That would have been divided into segments throughout the day and night. We felt at the time, and I think I'm correct in saying this, that it would be impracticable, and probably highly unfair, to ask anyone to sit and view CCTV for any more than a four-hour period. 16:31 16:31

401 Q. Yeah.

A. So, the day, if you like, was divided into four-hour slots.

402 Q. Okay.

A. And that's how the batching was...

403 Q. The purpose in asking for your recollection about that, the ordering in which the material was provided, is that we heard some evidence from some of the viewers who said that they recollect the material being somewhat random in order, it was jumping around from date to date and month to month. 16:32

A. Yeah. Yeah.

404 Q. And it has caused some practical difficulties for them, particularly later in the process when they also had the task of liaising with families and conveying information, you know, about incidents over spans of time which seemed to hop around, and families were getting repeated bits of bad news rather than having the opportunity on the part of the viewers to order it. 16:32 16:32

A. Yeah.

405 Q. And then go to the families with properly packaged information. Have you anything to say to that?

A. And I would totally agree with what you're saying. The difficulty with that there, and most of that probably occurred when we were asked initially to view the 25%, because I think I've explained that was totally random. 16:33

406 Q. Right.

A. In terms of the families getting the information, I don't believe, and I still don't believe there would have ever been any other way of being able to tell them in one conversation everything that would have had happened to their relative until all of the CCTV viewing had been completed. What was happening within 16:33

the hospital was, as each incident was viewed and noted, the family relative was being notified.

407 Q. Yeah. Well I suppose to play devil's advocate, if you like, there might have been -- one might not have pitched exactly for that potentially impractical outcome, but there might have been a more practical or more pragmatic solution, which might have been to at least allow the DAPOs, the Designated Adult Protection Officers, and others, to get some grasp, and at least organise the information in manageable chunks, rather than a drip, drip, drip of what was effectively quite traumatic information. Would you accept that there's some sense to that? 16:33 16:34

A. Obviously at this stage now, and looking back on hindsight, absolutely, yes. But I'm still not I suppose clear in my own head how that physically could have been done. And certainly when you hear it back now and so on, it certainly would have warranted a conversation as to how it could have been done better, but just sitting here today, I suppose without the opportunity to think it through, I'm still not quite sure in my own head how that could have been done, given the vast amount of CCTV that had to be viewed. 16:34 16:34

CHAIRPERSON: Could I just ask how it's ordered? So if I come in in the morning, was there a desk that you could sit at? 16:35

A. Yes.

CHAIRPERSON: Right. So you sit down at the desk, you turn the computer on, you get one screen or several

screens?
A. There was two screens.
CHAIRPERSON: Two screens. Right. And presumably you get a list of files which were in date order?
A. Yes. 16:35
CHAIRPERSON: Right.
A. It was actually a spreadsheet.
CHAIRPERSON: Okay. But you can organise that in date order?
A. Yeah. 16:35
CHAIRPERSON: Right. So the instruction was, effectively not do it randomly but to take a dip sample?
A. Yes.
CHAIRPERSON: Right. So why did it have to be random chronologically? 16:35
A. No, no, no, I'm not saying that it was done randomly chronologically, sorry. What I'm saying is when the agreement was reached for the first 25%, that was sort of like the dip sample. 16:36
CHAIRPERSON: Yeah. Yeah.
A. When we got to the stage, if you like, of all CCTV had to be viewed, that's when it became the chronological batching, if that --
CHAIRPERSON: Yes. But when we're looking at 25%, a dip sample of 25%, could that not have been done, a dip sample but in chronological order? In other words, you don't look at every day, but you don't do it randomly from one end of the chronology to the other, you just 16:36

do it in --

A. I don't honestly believe it was done that way. I still believe even the dip sample was done chronologically.

CHAIRPERSON: You think it was done chronologically.

A. I do fully understand what you're saying. 16:36

CHAIRPERSON: Yeah.

A. You know, you don't suddenly say "We'll do a part in June here and we'll go to August and then we'll come back to, you know, July", or something like that there. It didn't operate like that. It was done -- while it 16:36 was dip samples, it was still done in chronological order.

CHAIRPERSON: Right. And then when you're told that it all needs to be watched, then there's every reason to do that in a chronological order. 16:37

A. Which it was done.

CHAIRPERSON: But we have heard from the DAPOs who told us that it was random. So you would get a later date seen before an earlier date, they'd be telling families of what had happened to their relative, and then they 16:37 had to go back again and say "Oh, but a bit earlier something else happened." Now is that not your recollection?

A. It's certainly not my recollection nor my understanding. 16:37

PROFESSOR MURPHY: Could it have been --

DR. MAXWELL: If you're doing 25% sample, which had to be across the whole period, they would have gone and told families "Here's something in June."

A. Yeah.

DR. MAXWELL: And then when they get the instruction to do 100%, they have to go back to March. So, yes, the DAPOs would have got some things out of order, but that's not because it wasn't done logically. 16:37

CHAIRPERSON: Is that your recollection?

A. Absolutely.

CHAIRPERSON: Right. Okay.

PROFESSOR MURPHY: You did have a number of viewers, didn't you? 16:37

A. Sorry, I can't hear you?

PROFESSOR MURPHY: You had a number of viewers, didn't you? And I am just wondering how you allocated what to which viewer and whether they were working at the same time or at different times? 16:38

A. The process for the external viewers, generally that was after 5:00 o'clock in the evening through to 09:00 o'clock the next morning. Ehm, they would have completed viewing through the evening, through the night. They would have come in at weekends. How was 16:38 it allocated? Ehm, on people's availability. And it was back to the point that we were just making there in terms of "Look, this is what we need you to view for your shift", and then when the next viewers would have come in "This is what we need you to do for your shift" 16:38 - date, time, segment.

PROFESSOR MURPHY: So you would send that instruction to them by e-mail? Because presumably you weren't there all night, were you?

A. A lot of the time I thought I was! Ehm, but, no. The information would have been left in the office - it's coming back to me. The information would have been left in the office where the hardware was located. So, yes, there was --

PROFESSOR MURPHY: So they had keys to the office?

A. They did, yes.

PROFESSOR MURPHY: And did they go in just one at a time?

A. No, they would have always been in pairs. 16:39

PROFESSOR MURPHY: In pairs?

A. Yeah.

PROFESSOR MURPHY: Okay.

408 Q. MR. McEVOY: So in 24 then, you go on then and say that: 16:39

"At the start, I sat in with the viewers when they reviewed the CCTV just to show them how to operate the equipment. It was a complex system. Some viewers felt that they could view a number of cameras at the one time and the speed of the recordings could also be enhanced or slowed down. There could also be a number of cameras in the one area which showed different angles." 16:39 16:40

And you provided them with clips that were to be reviewed in accordance with what was agreed at the Core Hospital Group meetings.

"The viewers reviewed the CCTV and completed forms detailing what they had viewed in terms of camera, date and time.."

- sp this is a handwritten hard copy, is it? 16:40

A. Yeah, yeah.

409 Q.

"..and whether or not they had observed any untoward incidents, giving as much detail on the incident that they observed on the form as possible." 16:40

And as you've said a little bit earlier in your evidence:

"The viewer was required to record both positively if 16:40 an incident had been seen on a recording, or in the negative if no incident was seen. These forms were then placed into sealed envelopes and left in my office."

16:40

You weren't necessarily in your office all of the time. Was your office, therefore, unlocked in order to allow the viewers to leave those envelopes in?

A. No, the office was locked. They would have put them in envelopes and put them through at the bottom of the 16:41 door.

410 Q. Slid them under the door?

A. Yeah.

411 Q. Right.

A. But my office was specifically double-locked.
412 Q. Right. Okay.
A. For that very reason.
413 Q. All right. And how was that sort of hand recording and putting into sealed envelopes process devised? Who came up with that idea? 16:41
A. Ehm, I'm not sure. I'm honestly not sure.
414 Q. All right. You collated all the forms and passed all the forms to H507?
A. Yeah. 16:41
415 Q. You didn't comment or report on the forms, but you did update the spreadsheet?
A. Yes.
416 Q. All right. Which had details of what recordings had been viewed and what recordings still had to be viewed. 16:41 So does the spreadsheet capture all of the data from the viewing sheet or some of the data?
A. No, no, the spreadsheet was literally a spreadsheet of dates and times.
417 Q. And that's all? 16:42
A. It did not contain any information from the sheets that the viewers would have completed.
418 Q. Okay.
DR. MAXWELL: So it was just saying had it been viewed or not, so it was a "yes" or "no"? 16:42
A. The spreadsheet?
DR. MAXWELL: Yeah, on the spreadsheet. You've got the dates and times, and did you have "yes" for viewing?
A. It was colour-coded.

DR. MAXWELL: Sorry?
A. Sorry, it was colour-coded.
DR. MAXWELL: Right.
A. So when I knew, for example, say it was this morning and it was 8:00 til 12:00 midday or something like that there, once I was aware that those two viewers come in, done their shift, then I would have colour-coded, you know, I can't remember what the colours were now, but, you know. 16:42
DR. MAXWELL: No. Okay. 16:42
A. One was to say completed and the other was obviously still to be viewed.
CHAIRPERSON: And the form would also have on it, would it, a description, if there had been an event?
A. Absolutely. Yeah. I can basically tell you what was on the form. Like they would have had to record obviously their names, the date, the time segment that they were covering. And then there would have been areas, you know, for what was not right, what was right, and then -- 16:43
16:43
CHAIRPERSON: Sorry, what was not right about the behaviour of staff?
A. Absolutely. Yes.
CHAIRPERSON: Right.
A. And then -- 16:43
DR. MAXWELL: But also positive things when they saw good behaviour by staff?
A. Yes. Yeah, yeah. And then the last section of it really was for sort of general comments. Because we

did say to the viewers, I remember now as part of induction, that if they wished to make recommendations in terms of things that, you know, that they thought would improve, without it being an incident as such, but if they just were watching practice and thought "Well, look, you know, that could be improved by doing this, or that, or whatever", we did allow them the opportunity to make those recommendations.

PROFESSOR MURPHY: And they presumably didn't know the names of the staff they were watching because they didn't work for MAH? 16:44

A. No. No.

PROFESSOR MURPHY: So what would they say? They'd describe the staff member, would they?

A. They would have just literally said, you know, "staff", that was it. It was then down to us to go and view the time segment that they refer to and identify. And you could, you know, identify out of the description that they had provided, you know, who the patients were, or who the staff were, or whatever. 16:44

DR. MAXWELL: So they were essentially triaging it?

A. Sorry?

DR. MAXWELL: So they were essentially triaging the CCTV?

A. The viewers? 16:45

DR. MAXWELL: The viewers. They were saying "Here's something that we think is a problem or is excellent."

A. Yes.

DR. MAXWELL: They wrote this on a form, that went to

H507, who discussed that with senior managers, and things that were considered to be incidents were then referred to the adult safeguarding team. Was this before people had gone back and identified who the staff were? Did they go to adult safeguarding and then the CCTV was looked at again?

A. Ehm, no, my recollection is that once they would have discussed it, it went to the adult safeguarding team, they would have came in then and viewed the CCTV themselves. 16:45

DR. MAXWELL: Yeah. So H507 wasn't looking at it before the referral to the safeguarding team?

A. No. No, no.

DR. MAXWELL: So between the reviewers, nobody was looking at it again before it got to the adult safeguarding team? 16:45

A. Ehm, no, no, that's right.

CHAIRPERSON: So you didn't look at any of it?

A. No, no.

CHAIRPERSON: And when you say you collated the forms. 16:46

A. Sorry?

CHAIRPERSON: You say in your statement "I collated the forms", in other words the forms --

A. I essentially mean that they were all sent to me.

CHAIRPERSON: No, I understand that, but I just want to understand what you did with them. Did you open the envelops? Were they in envelopes? 16:46

A. Oh, absolutely, yes.

CHAIRPERSON: Right. So you opened the envelopes.

A. Yeah.
CHAIRPERSON: Did you collate them in date order or did you separate those where there were incidents as to where there weren't? What did you do with them?
A. Yes, the envelops were opened. I would have separated them into "incident", "no incident", but everything was handed over to H507. 16:46
CHAIRPERSON: Right. So apart from that purpose, as it were, to collate them, did you read the forms?
A. Yeah. Well, I had to read them to establish whether there was an incident or no incident. 16:47
CHAIRPERSON: No, I -- sorry, I put that badly. But did you read the detail, as it were, and take a view yourself?
A. No. 16:47
CHAIRPERSON: In any way...
A. No.
CHAIRPERSON: As to whether an incident was a safeguarding incident or not?
A. No. No. A number of reasons for that. Simply by reading a piece of paper does not give you the picture of whether there has been an incident or not, that's interpretation by somebody. It's quite possible that others would view it and say "Well, actually, you know, there hasn't been an incident there." So, no, I would not have formed any views whether -- and it would not have been within my role... 16:47 16:47
CHAIRPERSON: No.
A. To form views.

CHAIRPERSON: No, I understand that. And for that reason you never looked at the incidents on CCTV yourself?

A. I would have seen a lot of the incidents simply because -- sorry, I would have seen a lot of the incidents in the early days, simply because when we began to view the CCTV I had to be in the room for the operation of the equipment. 16:48

CHAIRPERSON: Yes. Right.

A. And I would have also been with the two adult safeguarding people who were allocated to this. If you think of the external viewers and the shifts that they were doing, they would not have been starting any shift until after 5:00 o'clock in the evening, and that was to allow for viewing of any reported incidents by the external viewers from nine in the morning to five in the evening, that our own staff could view to establish if there had been an incident. 16:48 16:48

CHAIRPERSON: Right. Yeah. So were there occasions when you were watching the CCTV with the reviewers? 16:48

A. Mhm-mhm.

CHAIRPERSON: And were there occasions when you offered an opinion as to whether something amounted to a safeguarding event or not?

A. Absolutely not. Absolutely not, no. And I want to be categorically clear about this, because I would not have been qualified to do so. And particularly in things like, you know, if MAPA techniques were being used or something, I was never MAPA trained, I wouldn't 16:49

have known if the techniques were correct, incorrect, or otherwise.

CHAIRPERSON: Right.

A. So I would not have offered opinions.

CHAIRPERSON: So you're saying your role was purely to facilitate the view? 16:49

A. Absolutely.

CHAIRPERSON: And you offered no view.

A. Absolutely. That is 100% correct.

CHAIRPERSON: We have that evidence. Thank you. 16:49

A. Yeah. Yeah.

419 Q. MR. McEVOY: All right. Well, that rather takes care of the next series of questions I was going to ask you.

CHAIRPERSON: Oh, sorry, Mr. McEvoy.

420 Q. MR. McEVOY: No, I think everybody is glad to hear that! But Mr. Ingram, I just wanted to touch then on what you say in paragraph 26 then about facilitating the viewing of the material by the police and providing copies of recordings as they wanted them, and we've touched on that a few moments ago, was it the same process throughout of a physical disc, CD-ROM or DVD, or something that of order? 16:49 16:50

A. Yes. And I suppose just to clarify that when the downloading was being done on to the CD-ROM, there were always two copies made. 16:50

421 Q. Right.

A. One for the PSNI and one for the Trust. And the reason for that was that were there to be any follow-up disciplinary proceedings, the evidence would still be

there. Bearing in mind what I said earlier that the system only had capacity for X amount of recording and would have then began overwriting.

422 Q. Okay, and we'll come right back to that point. Just before I do, I think we can see from the evidence in your statement that there was an initial 25% of footage looked at, and we've talked about how then this went up to 50% then, and you tell us that in paragraph 25. At some point in time you say: 16:50

16:51

"I can't recall when I was advised that we needed to now review all of the CCTV footage."

In other words, that would be 100%. Would that maybe have been later on in 2017, around November time, to jog your recollection? Not too much further into the distance, in other words, from August. 16:51

A. I think it certainly was towards the latter end of 2017, yeah.

423 Q. All right. 16:51

A. Yeah, yeah. If I'm right in saying that.

424 Q. So you have just told us about how two copies were retained?

A. Yeah.

425 Q. And one was -- sorry, two copies were made, I beg your pardon, and one was retained? 16:51

A. Yeah.

426 Q. And you say that that was for internal purposes, including potentially disciplinary investigations?

A. Absolutely. Yeah, yeah.
427 Q. But you were advised then by H287 that she had been advised by Marie Heaney, who was the Co-Director of the hospital, that the police had taken a decision that they would remove the CCTV footage from the hospital to take a full copy of the same, which they did, and then the police handed back the footage to the Belfast Trust in segments. So you had some material which you had retained a copy of, and then once the police came in and took - they take the physical hard drive, just so we understand? 16:52 16:52
A. Well, I think I need to explain this just maybe in a wee bit of detail here.
428 Q. Okay. It would certainly help if you can.
A. Yeah, what was happening here. Ehm, the police had taken a decision, and I don't -- obviously I have no idea about that -- but they had taken a decision that they wanted a complete copy of the CCTV system, and they were going to come to the hospital to make that copy, and I was actually there on the day that they came do it and they had brought the wrong obviously IT technical people and so on with them to do that. 16:52 16:53
429 Q. Mhm-mhm.
A. But during the process of them trying to obtain a copy of what was on the system, there was some sort of malfunction. Now, we were never made aware of what that malfunction was. And, in essence, no CCTV could be viewed, because it seemed to have disappeared. Now, the system was then removed from the hospital and sent 16:53

to Dublin to be, for the want of better words, rebuilt.

430 Q. Yeah.

A. And then at that point --

431 Q. Just on that point. Whose decision was that or at whose direction was that done? 16:54

A. Oh, that was the police.

432 Q. Yeah.

A. Yeah. Now, I can't honestly remember the exact length of time, but I think it was probably a couple of months where there was no CCTV viewing, for that very reason, 16:54 because we had nothing to view.

433 Q. Yeah.

A. And when it was retrieved, it was not brought back to the hospital. The police then actually held on to it, but did make a copy of it to give back to us, but it 16:54 was -- there was a whole different way of managing it thereafter.

434 Q. Sorry, just so we understand this correctly, and I know I'm probably oversimplifying here, but they retained the original physical -- 16:54

A. Hardware.

435 Q. Hardware.

A. Yeah.

436 Q. And then gave you, it having been restored, gave you a copy of its contents. Is that right? 16:54

A. Yes, yes.

CHAIRPERSON: But in what form? On a hard drive?

A. Yes. This is what I wanted to go on to say. It wasn't on a hard drive and it wasn't on CD-ROMs. They were

like cartridges. They're difficult to describe unless you physically see one, but they're like cartridges. They're like the old VHS videos that would you have put into a video machine.

CHAIRPERSON: I was just thinking that. 16:55

A. And they weren't actually returned to Muckamore itself, they went to a secure location in -- oh, I've forgot the name.

CHAIRPERSON: Don't worry. Did they go back to the Trust? 16:55

A. They did come back to the Trust, to one of the hospitals in the Trust. I've forgotten. Oh.

CHAIRPERSON: It may not matter.

437 Q. MR. McEVOY: That's okay. Yeah. No. But they went somewhere within the Trust anyway. 16:55

A. Yes, yes.

438 Q. That's the key point.

A. No, absolutely. Yeah, yeah, yeah.

439 Q. All right. Okay. And then the footage review process you say would have commenced again once the recordings were returned in segments. That did happen, is that right? 16:55

A. Mhm-mhm, yeah.

440 Q. And had the process -- the Inquiry has heard evidence about this, but just so we are a little bit clear about your understanding. Was the process, when the material was returned, different? Was there a different process employed by the Trust for the viewing? 16:56

A. Ehm, not as far as I'm aware, no.

CHAIRPERSON: Sorry, but you've now got effectively a VHS. I presume you had to build a system or buy a system that could view that. The system that the police had returned to you was not the hard drives that you had been working with before, or is that wrong? 16:56

A. I honestly can't remember, but I do know the equipment was all there to be able to utilise what they had returned to us.

CHAIRPERSON: So you were able to.

DR. MAXWELL: Did you continue to be responsible for overseeing the viewing at this new location when it came back, or was that somebody else's job? 16:56

A. Ehm, no, that was still my role.

DR. MAXWELL: That was still your job?

A. Yeah. Yeah. But it wasn't for much longer after that, because I think we were getting very close to the point around where I retired. 16:57

441 Q. MR. McEVOY: All right. So you're not, as far as you're aware there was no change to the process. Was it the same viewing? Was the same -- I mean presumably because we weren't in the administration building anymore we couldn't have envelopes slipped under your door. 16:57

A. No, there was no more of that.

442 Q. Right. So that does suggest then that there was some tweak to the process at least of viewing and recording of incidents. Would that be right? 16:57

A. Sorry, I may have misinterpreted what you're saying to me. If we're talking about the external viewers

viewing, I think that ceased at the point that the police took the system.

443 Q. Yeah.

A. When I say they returned it via cassette format, there was no more, as I understand it, external viewers viewing it. What we had -- 16:58

444 Q. We had a witness talk about Phase 1 and Phase 2 viewing. Does that ring a bell with you? Does that chime with you? Described Phase 1 as being sort of external, kind of the external viewing, and then Phase 2 being more DAPO led? 16:58

A. Oh, yes, yes, that would be familiar. But what I'm saying to you is, in terms of the external viewers having access to view, that stopped, I believe, as far as my memory serves me, that stopped at the point that the police took the hardware from the hospital. 16:58

445 Q. Right. Okay?

A. And what was happening when it was returned in the other hospital, whose name still escapes me, was the DAPOs and approved social workers, I can't even remember all their terms now, but that was when they were continuing to view. There was quite a backlog, if you like, of incidents that still had to be viewed, so they were doing and clearing that backlog. 16:59

CHAIRPERSON: That didn't involve any assessment sheets or sheets that had to be put under your door? 16:59

A. No, they would have been using their own recognised forms. I can't remember what they were called? ASPs or JPs or something like that there.

DR. MAXWELL: So essentially the triaging function stopped?

A. As far as I remember, yes.

DR. MAXWELL: And adult safeguarding were looking at everything. So they didn't need to fill in a form for you which then somebody had to decide whether to send on to them, they were seeing 100%? 16:59

A. No, no, there was no more of that.

446 Q. MR. McEVOY: Okay. I know you're - and it's no discredit to you, you're a little bit vague about that, but was there an explanation given to you for this change in process, why there was no need to, why there was a need to tweak things from the, or change things from the previous process? 17:00

A. I'm sorry, but I don't think you're actually understanding what I'm saying. 17:00

447 Q. Right.

A. When it was returned to us, that was at a point in time.

448 Q. Yeah. Yeah. 17:00

A. So, you know, the way that it had been returned to us and so on, I don't know if the external viewers could have viewed it? I genuinely don't know.

449 Q. Yeah.

A. What I'm saying to you is, what was returned to us in cassette format, there was only the DAPOs and whatever the other -- not the external viewers, just these people doing this catchup on the backlog. 17:00

450 Q. Yes.

A. There was no new viewing done.
451 Q. Yes.
A. I don't know if that makes sense, does it
DR. MAXWELL: Sorry, are you saying that the external viewers had reviewed everything? 17:01
A. No, no, no, no, they hadn't. No, they hadn't. What I'm saying is the process stopped because the police had a copy of the system.
DR. MAXWELL: No, I understand that. But when the social workers of whatever description took over, 17:01
you've said there was a backlog. Was that a backlog of incidents that had been identified by the external viewers?
A. Yes. Yes. Yes, absolutely.
DR. MAXWELL: And so it needed an approved social 17:01
worker or a DAPO.
A. Yes.
DR. MAXWELL: Because it had already been identified as an incident.
A. Yes. 17:01
DR. MAXWELL: And that's what they were looking at. That's why the externals wouldn't have been able to do it?
A. Absolutely. Yes, yes, yes. That's exactly right.
DR. MAXWELL: Yes. So it wasn't a change in policy, it 17:01
was just another part of the policy.
A. Yes, yes.
452 Q. MR. McEVOY: So another part of the policy being activated then, was the external viewing still going on

then? Was that continuing?

A. No, no, no, because the police had the full copy of the system and they were taking on the responsibility for viewing it.

453 Q. You're quite right, I don't understand. So there was no, there was no more external -- that part of the process -- 17:01

A. No.

454 Q. -- fell away?

A. Yes. 17:02

455 Q. And was it explained to you? I mean you're saying that's because the police had possession of the material.

A. Mhm-mhm. And that's what was explained to me.

456 Q. By whom? 17:02

A. Ehm...

DR. MAXWELL: So the police had essentially replaced the external viewers? They were doing the triaging?

A. Essentially, yes. Essentially.

DR. MAXWELL: And then they were saying "Here's an incident. Can the social worker have a look at it under the Joint Protocol?" 17:02

A. Yes. Yeah.

CHAIRPERSON: Is that right?

A. That's right. That's right, yeah. 17:02

CHAIRPERSON: That's your recollection.

A. That's my understanding, yes.

CHAIRPERSON: But can I just understand this? At the point that the police took away, for want of a better

expression, the hard drives, you would not say that 100% had been looked at by that stage?

A. No, no.

CHAIRPERSON: Are you able to say how much of it had been looked at? 17:02

A. Oh, I honestly couldn't, no. No, I wouldn't even pretend to try and put a figure on it.

CHAIRPERSON: Right. Sure. Okay. Then the police take it away, they view it. When they returned, let's call them discs, whatever they are, to you, was that 17:03 all of the material? Was that a copy of all of the material that had been handed over to the police, or was it just the material that the police were asking somebody to review?

A. No, no, it was a copy of what was on the system at the 17:03 point that they removed it.

CHAIRPERSON: Right. So the whole lot?

A. Yeah.

CHAIRPERSON: Okay. And then were the police asking somebody to review the material that they had 17:03 identified?

A. I assume, without any form of authority here, I assume that they were still asking the Trust and all safeguarding people to do that.

CHAIRPERSON: But were you involved in that process? 17:03

A. For a very, very short space of time, and that was more do with identifying patients and staff. But at that time it was in, if I remember rightly Antrim Road Police Station, and I do remember going to it a couple

of times, not very often, and as I say I think my time with the whole process was probably coming to an end at that stage.

CHAIRPERSON: So you weren't viewing it now at the hospital, you were viewing it at Antrim Police Station? 17:04

A. For identification purposes. Not to decide if there had been an incident.

CHAIRPERSON: And were you -- no, sure. And were you in a position to identify people?

A. Some. Not all. 17:04

CHAIRPERSON: Right. Thank you.

457 Q. MR. McEVOY: So I just want to be clear about this in my own mind. When the copy of the material on the new system is back with you, there is no more external viewing? 17:04

A. No.

458 Q. And can you just help us understand who communicated that decision to you, or that new way of doing things to you?

A. I don't remember individually who had told me, but I do 17:04 remember thinking, or not thinking, but I do remember at the time knowing that this ain't coming back to us, so really our involvement, if you like, ends here.

459 Q. It's in the hands of the police, in other words?

A. It's in the hands of the police. 17:05

460 Q. Right. Okay.

A. And I think also part of the reason for them removing it was they were quite concerned about the security.

461 Q. Yes.

A. Of the system being at Muckamore.
462 Q. Yes.
A. And I think they thought that perhaps they could offer better levels of security for it than where it was located in the hospital. 17:05
463 Q. Did you - and this is really final point - did you discuss with them and make them aware of the system that you had been running, you, plural, had been running? In other words, with the form being filled in, handwritten in a sealed envelope, and then being 17:05 put under your door, were the police aware of that?
A. They would have been aware of that via adult safeguarding.
464 Q. Okay. And do you know whether the police ever conveyed of you about the... 17:05
A. If the police what, sorry?
465 Q. If the police ever expressed a view about the right or wrong, the propriety of that, of that process?
A. I'm not sure that I understand.
CHAIRPERSON: Well, I'm not sure we're really 17:06 interested in the police's view.
MR. McEVOY: All right. Okay.
CHAIRPERSON: Right. Dr. Maxwell, do you have anything? No.
17:06
Can I thank you very much for coming along to assist the Inquiry. It's been quite an extended session this afternoon, so thank you for your patience.
Can I also thank the stenographer. I did check that

she was all right at about 4:30, but she probably didn't expect us to go on quite so long, but thank you very much indeed. Thank you. You're released.

A. Thank you.

CHAIRPERSON: And we'll sit at 10:00 o'clock tomorrow. 17:06

THE INQUIRY ADJOURNED TO THURSDAY, 12TH SEPTEMBER 2024, AT 10:00 A.M.