ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Tracy Hawthorne
Date: 11th September 2024

I, Tracy Hawthorne, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made on behalf of the Police Service of Northern Ireland in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be "Exhibit 1"

Qualifications and positions

1. I am a Detective Constable in the Police Service of Northern Ireland (PSNI). I currently hold the position of Crime Trainer at the Police College Crime Faculty.

2. During a 20-year policing career I have held the following positions:

    a. (2004 to 2008) I was a Constable within Carrickfergus District.
    b. (2008 to 2015) Missing and Vulnerable Persons/ Adult Safeguarding Officer (Constable) within D District Public Protection Unit.

c. (2015-2015) Adult Safeguarding Officer attached to Northern Trust Public Protection Branch.
d. (2015-2019) Detective Constable, Child Abuse Investigation Unit.
e. (2019-2022) Seconded to Belfast Trust Public Protection Unit investigation into Muckamore Abbey Hospital.
f. (2022-2024) Crime Trainer, Crime Faculty, Knocknagoney.

3. Therefore, the majority of my policing service has been connected to Public Protection work.

Module

4. I have been asked to provide a statement for the purpose of M4: Police role in safeguarding and responding to allegations.

5. My evidence relates to paragraph 13 of the Inquiry's Terms of Reference.

6. I have been asked to provide a statement for the purpose of assisting the Inquiry in understanding the role of Police involvement in Adult Safeguarding at Muckamore Abbey Hospital between 2008 and 2014.

PSNI and Ennis investigation

7. In the correspondence dated 22 February 2024 the MAHI provided the following question:

Q.6 On 31 July 2021, the report by the Muckamore Abbey Hospital Review Team, titled "A Review of Leadership and Governance at Muckamore Abbey Hospital" concluded (with regard to investigative action taken by the Trust) that:

"the Ennis allegations constituted institutional abuse. A wider investigation at that time should have been undertaken in order to determine what, if any, issues existed in other wards" [page 123].

Did PSNI consider conducting a wider police investigation into whether abuse was happening in other wards at MAH at that time? Please describe any decision making and/or action taken by PSNI in this regard.

8. I was the Investigating Officer in the investigation into alleged abuse in Ennis Ward, which was reported to me on the 8th of November 2012. The Case file is Police Reference C13011914.

9. The subject of potential institutional abuse was a matter for discussion during the Joint Investigation. It was of significant concern that the alleged actions were openly carried out in front of staff from the private provider.

10. The main witness in the Ennis investigation reported that she had worked on other wards within the hospital during the resettlement process and her experience on the other wards had been positive.

11. Viewing the allegations in the context of having investigated a number of cases within the hospital, including those where members of staff had reported wrong doing by colleagues, it was my view that MAH appeared pro-active in reporting matters to PSNI. The information available at the time, from the private provider staff, suggested that the issues appeared to be isolated to practices within Ennis ward, rather than hospital-wide institutional abuse. There was no information provided at that time to suggest similar practices were occurring on other wards.

12. During other investigations relating to allegations against staff members, when recording witness statements, comments had been made by nursing staff witnesses that they were cognisant of the implications for not reporting alleged wrong doing by colleagues. It was also frequently reported by staff witnesses that a positive obligation had been placed on them to co-operate with police

investigations, by the Nurse Manager and that failure to do so may result in disciplinary action being taken. Therefore, it had been my experience that the hospital staff generally presented as being co-operative with police.

13. The Nurse Manager was always co-operative with police and would provide information and co-ordinate interviews with staff witnesses. I had several conversations with him about introducing CCTV on the wards, having witnessed its effectiveness in another hospital, particularly on the occasions where false allegations had been made against staff and it had been possible to dispel these very quickly by reviewing the footage. The Nurse Manager expressed that he had been advocating for the introduction of CCTV, but there had been resistance to it.

Covert CCTV

14. As a result of the concerns, it was proposed by DSgt McCormill, on the 13th of November 2012, that covert CCTV could be installed in Ennis Ward. Police were cognisant that MAH had a significant proportion of staff across all wards and Bands who were related. Therefore, in order to maintain the integrity of the investigation, staff from MAH, save for the Service Manager, were subsequently excluded from multi-disciplinary meetings. Discussions in relation to covert CCTV were limited to a 'need to know' basis and I only recall discussing this proposed investigation strategy with Aine Morrison. It was my understanding this was raised with Trust management who were consulting their legal department.

15. In November 2012 DSgt McCormill applied and received approval for installation of covert CCTV. It was essential that the Trust co-operated with police to facilitate this. It was expressed, I believe, by Aine Morrison that it may be difficult to place cameras in the ward without staff noticing, due to the need for staff to be present 24/7 to care for patients and that it may be disruptive and

upsetting for the patients on the ward to either be moved to allow for installation or for strangers to be in the ward whilst patients were present.

16. Following the allegations being made on 8th November 2012, the Trust increased monitoring of staff on Ennis Ward. Police awaited a decision from the Trust as to whether they would allow covert cameras to be installed. On the 21st of December 2012 DSgt McCormill advised D/Supt Smyth that the Trust had decided not to provide authorisation for covert cameras. I completed a further Occurrence Enquiry Log entry dated 29th January 2013 (see 'Exhibit 1') which records contact with Aine Morrison. Aine Morrison informed me that the Trust had still not made a decision about the installation of covert cameras and enquired whether PSNI still wished to pursue this.

17. Taking into consideration the Trust had notified DSgt McCormill in December 2012 they did not wish to have cameras installed, that almost 12 weeks had passed since the initial report and that no issues had been identified during that time, my view was that the time for such action had passed. Staff were under increased monitoring and supervision and it was my view that it would be less likely that any wrong doing would be captured in those circumstances. I informed Aine Morrison of this, informing her that I would pass this to DSgt McCormill for consideration.

18. The MAHI correspondence of 22 February 2024 further seeks a response to the question below:

Q7. Does PSNI wish to draw the attention of the Panel to any other matters relating to the PSNI investigation into incidents which took place in Ennis ward in and around November 2012?"

19. The July 2020 report by the Muckamore Abbey Hospital Review Team, entitled "A Review of Leadership and Governance at Muckamore Abbey Hospital", at point 8.45, states that there was a 'significant delay' in police interviews with the two suspects. At the outset, I wish to highlight that, despite being the

Investigating Officer in the case, I was not consulted by the author of this report and am of the view that consultation with police would have been beneficial prior to its completion and submission. (see pg 703, Ennis Bundle) This is on the basis that police could have assisted with:

a) clarifying the timeline and process of gathering evidence in the investigation
b) providing an explanation as to why the alleged suspects had not been arrested or interviewed sooner
c) clarifying circumstances of what has been perceived as 'significant delay'.

20. In order to assist the Inquiry, I have prepared a Timeline of the police investigation. (see 'Exhibit 2')

21. In order to assist the Inquiry in understanding any perceived delay, it may be of assistance to provide some context in relation to processes at that time.

22. The report in relation to Ennis was logged at approximately 17:06 on 08/11/12. The principal witness in the case was spoken to and a statement was recorded the following day. A detailed synopsis of the allegations made was forwarded to the Designated Officer at the Hospital Social Work Team, Belfast Trust and two Management staff at MAH (see 'Exhibit 3').

23. At the time of report, there was an initial telephone strategy, this was a conversation with the hospital social work department's DAPO, to agree an initial investigation plan and immediate actions. This included an agreement to conduct pre-interview assessments with all patients on the ward. At that time, due to the complex needs of many of the hospital patients, pre-interview assessments were not conducted without approval from medical staff, predominantly the ward Consultant Psychiatrist. This approval would have been sought by the hospital social work department prior to or shortly after referral to police, on most occasions.

24. I attended Multi-agency Strategy Meetings on 09/11/12, 15/11/12, 12/12/12, 20/12/12, 05/07/13 along with DSgt McCormill. These were intended as meetings to discuss and agree actions to progress the Joint Protocol Investigation and ensure that patients were being protected. During the meeting on 09/11/12 it was agreed, as part of the multi-disciplinary meeting, that the Trust would conduct interviews with other service provider staff who had attended Ennis Ward as part of the re-settlement and that police would be notified if any alleged criminal offences were disclosed. Generally, this would be done to assist the Trust's investigation by ascertaining practice issues, whilst safeguarding against any suggestion that police had been seeking to solicit further criminal allegations against staff. On occasion, DSgt McCormill and I would leave the meetings when the focus switched to HR staffing and management conversations not directly related to safeguarding. I recollect DSgt McCormill and I querying the continued necessity for HR to be involved in the safeguarding meetings.

25. Detailed information as to the allegations being made were provided verbally at the Multi-disciplinary meetings, and in writing to the DAPO, who was also regularly updated as to the progress in the investigation. Requests were made by police that specific details of the allegations were not disclosed to staff in order to preserve the integrity of the investigation, particularly prior to the suspect interviews. This did not preclude, however, the nature of the types of allegations under investigation being shared to allow for adequate protection plans to be devised. I have no recollection of any commentary pertaining to PSNI not sharing information and this having a direct impact on the ability to supervise Ennis staff. I was always mindful of the need to share detailed, precise information about reports and allegations to ensure that the Trust was aware of all criminal allegations and care practice issues to assist in addressing all safeguarding aspects as part of the joint investigation.

26. Where criminal allegations were made by Service Provider witnesses, PSNI undertook to record the statement(s) in relation to these allegations. The majority of concerns that were raised presented as being care practice issues, as opposed to clear criminal offences, therefore, it was agreed that the Trust

would complete interviews with all of the Care Provider staff who had attended MAH and alert PSNI should any of their reports allude to potential criminal offences.

27. Quite often the issue of resourcing, costs implications of additional resources and staff suspensions caused by the investigation featured heavily in multi-disciplinary meetings. As Investigating Officer, I was of the view that there was an imbalance of focus, particularly from the Trust's Human Resources Department on the financial implications of the investigation, proposed protection plans and a degree of pressure on the Trust's Investigation Team to mitigate these by, for example, expediting disciplinary proceedings. DSgt McCormill and I had cautioned against disciplinary action being taken whilst a criminal investigation was on-going, in order to avoid contamination of evidence. However, we declined to involve ourselves in discussions as to the employment status of the staff suspects, as we felt this was a resource management issue and, therefore, a matter for the Trust to ascertain whether there were roles that these staff could be re-positioned to whilst the investigation was on-going (for example, see pg 47 Ennis Bundle).

28. I note in "A Review of Leadership and Governance at Muckamore Abbey Hospital" there is reference to Serious Adverse Incidents (SAI) and the fact that the Ennis investigation had not been raised as an SAI. Although I do not specifically recall the matter of SAI being tabled during the multi-agency meetings, to my view SAI would be an internal regulatory process for the Trust and, therefore, Police would not have pressed for the investigation to be declared as such. As part of the wider multi-disciplinary discussion attendees (including PSNI) views may be sought about declaration of SAI. Had it been raised; I would not have suggested delaying declaring the investigation a SIA as I would not have perceived it to have had any negative impact on or impeded the conduct of the police investigation.

29. On 04/12/12 an additional meeting was held with the Consultant Psychiatrist, a Speech and Language Therapist and the Trust Designated Officer to discuss the possibility of attempting to interview patients. Only one of the patients named by the witness was deemed capable of providing some form of account. Six other patients were identified as possibly being able to be spoken to about patient experience, but it was recognised that these discussions would require assistance from a Speech and Language Therapist.

30. At this time the Registered Intermediary Scheme was not available and therefore police were dependent on the Trust assisting with arranging input from SALT. This resulted in a delay to Pre-interview Assessments being conducted. These took place on 23/01/13.

31. Three patients were ultimately deemed able to be spoken to in connection with the investigation. One patient (a named alleged victim) was extremely difficult to engage with. She was directly asked whether she had hurt her mouth, several times but was unable to provide a coherent response to the question. The other two patients engaged in conversation but expressed no dissatisfaction with staff. PSNI recognise that there was a delay in conducting these assessments, due to the complexities of trying to arrange speech and language input to maximise communication. At the time of the assessment, the staff suspects had not been working on the ward for over six weeks and therefore, aside from communication difficulties and learning difference, it may have been difficult for the patients to associate the visit with incidents that had occurred several weeks ago, without being directly leading and mentioning names of the staff involved.

32. The Public Prosecution Service made reference to consideration for engaging the Registered Intermediary Scheme at prosecution stage but noted that this was not required as the prosecution case was not reliant on patient accounts.

33. I attended meetings on 29/03/13, 28/10/13 and 08/04/14 alone. On the last meeting those present were advised that the Adult Safeguarding Investigation was now closed. Comment was made by the Service Manager in relation to 'anger and upset' demonstrated by Ennis staff having been made aware of the allegations. I expressed concerns in relation to the reported reaction of staff which suggested that they disbelieved the allegations (See Pg 80 of the Ennis Bundle).

34. The PPS directed prosecution on the Ennis case in relation to one Nurse and one Health Care Support Worker ('HCSW'). The Nurse was found Not Guilty of the offences of Common Assault and Hospital Staff Ill-treating a Mental Patient. The HCSW was found Guilty of Common Assault and Not Guilty of Hospital Staff Ill-treating a Mental Patient, at Antrim Magistrates' Court on 20/11/14. The HCSW received a two-month sentence, suspended for two years.

35. Neither witness was prosecuted for the Ill-Treatment of a Mental patient offences. [redacted]

[redacted]

Redaction of this text and Exhibit 4 is necessary to protect the identification of staff implicated in abuse as required by Restriction Order No. 4 (see Restriction Order No. 87).

36. The HCSW appealed the conviction. The appeal was heard on 03/02/15 at Coleraine Crown Court in relation to one count of Common Assault only and, therefore, only the witnesses relevant to this specific allegation were called to give evidence. The principal witness from the original case had returned from Australia to give evidence at the appeal, which, to my recollection, she did. The

Nurse (former co-accused) attended and presented witness evidence in support of the HCSW. The conviction was overturned.

37. During the period from 2008 to 2015, I was the only officer completing the Adult Safeguarding role within my District, which consisted of Antrim, Carrickfergus, Newtownabbey and Lisburn Borough Council areas (at that time Lisburn included Polegalss and Twinbrook). During this time, I continued to receive a large number of Adult Safeguarding referrals. Between the referral in relation to Ennis being received on 08/11/12 and the case file being initially submitted to PPS on 28/03/12, I had been assigned investigating officer for over 250 reported incidents. The vast majority of referrals I received were from Muckamore Abbey Hospital.

General

38. The correspondence further invites a response to the question below:

Q.8Does PSNI wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of paragraph 13 of the Terms of Reference?

39. My Policing District covered South Eastern, Northern and Belfast Trust areas. As MAH was a regional facility, however, investigations would be passed to the patient's owning Trust, who would be tasked to provide trained Social Workers to assist with Pre-interview assessments and interviews (as required). As a result, I had contact with Social Work teams from throughout the province.

40. It would not have been uncommon to receive in excess of 20 referrals from Muckamore Abbey Hospital each week, predominantly peer on peer incidents, most of which had to be recorded as 'assaults' in order to adhere to Home

Office counting rules. Belfast Trust adhered strictly to the Joint Protocol, which, at the time, stipulated all incidents of a criminal nature must be reported to police. This included incidents in which very unwell patients may have hit or pushed a peer who was not in a position to make a complaint or declined police involvement.

41. This resulted in inflated violent crime figures for the area, but also concerns about criminalising severely learning-disabled patients. Approaches were made to the Belfast Trust suggesting a modified approach to reduce Joint Protocol referrals, but Belfast Trust declined to alter their practices unless the Joint Protocol was amended to allow for more discretion.

42. At this time Central Referral Unit did not exist, therefore, I was required to complete the following tasks for each reported incident:

- create a Command-and-Control entry to record each incident and where relevant request an Investigating Officer be assigned from the relevant department.
- phone and record each individual report with Call Management, who would add the details of persons involved, offences alleged and link addresses
- Update Occurrence Enquiry Logs with agreed strategies and whether any further investigation would take place.
- Arrange pre-interview assessment (and ABEs if required).

43. Due to the volume of reports from MAH alone, it was agreed that a 'clinic' would take place twice weekly to discuss each incident, rather than reporting them through, ad hoc. The exception to this would be if there was a serious or significant live incident that required immediate action.

44. Due to the volume of incidents reported by MAH and the fact that all alleged victims were adults, I depended on the hospital Social Work team to update

relatives where required and pass on my details, should they wish to discuss the police involvement in the investigation.

45. I would be at MAH almost every week, often on more than one occasion and would collect the Adult Joint Protocol documents from the Social Work team and conduct Pre-interview Assessments.

46. Patients at the hospital were from across the province. It was predominantly a trained Social Worker from the 'owning' Trust that would complete the Pre-interview assessments and ABEs (when required).

47. Where Protection Plans had been put in place, if referrals continued to be received, this would be flagged with the Designated Officer at the hospital, who would seek to identify patterns or reasons for further incidents. I recall the DAPO had noted an increase in patient-on-patient incidents during the lead up to Christmas on some wards. It had been considered that the build-up was affecting behaviours. The DAPO informed me he had directed that decorations only be put up one week before Christmas in an attempt to mitigate this.

48. Senior medical staff would indicate that some of the patient-on-patient issues were environmental, for example, having to accommodate patients with severe autism and sensory issues together, in one ward was detrimental to their treatment, but there were no other alternative facilities available within NI to place them in. One Consultant Psychiatrist would regularly quote the Hippocratic Oath and highlight that, for certain patients, remaining in the ward environment was causing them harm.

49. Where patients made allegations against staff members, these rarely progressed to decisions to prosecute. Often the alleged incidents would be deemed 'Physical Interventions' for the patient's own safety and detailed, hand-written paperwork supporting this account would be provided.

50. Additionally, it would regularly be reported, during multi-agency discussions, that patients making allegations against staff would have a 'history of making false allegations' or be 'unreliable historians'. This made progressing successful cases, which relied on patient evidence, incredibly difficult due to such comments recorded in medical documents which impacted on the patient's credibility as a witness.

51. The few cases that did progress to court were those where staff witnesses had reported wrong doing. It seemed difficult to secure convictions, as outlined in the cases below, and in particular for the offence of Ill-treatment of a Patient, as seen in the Ennis investigation.

52. In one of my investigations (Pre-Ennis - Case file C12003853 refers), a HCSW was witnessed by other staff members to punch a patient to the head. The matter was investigated and five staff members provided witness statements. Prosecution was recommended by police. A prosecutorial decision directing prosecution was made by the Public Prosecution Service and the matter progressed to Antrim Magistrate's Court, however, on the day of hearing, at court, the HCSW was offered and accepted an Adult Caution.

53. In another case (Post- Ennis, Case file C14022511) a temporary HCSW reported that she had allegedly witnessed another HCSW holding a patient by the jaw and pulling him from the floor of the bathroom onto his feet after the patient defecated in the shower before directing him to go into the toilet and physically pushing him into to toilet area. The witness alleged that the HCSW then took a razor from the patient's washbag saying, 'dry shave it is then' and returning to the toilet area. The patient appeared to have been shaved when he re-emerged from the toilet area. The witness reported the matter the following day to the Deputy Charge Nurse. None of the other staff on duty reported witnessing anything. The matter was investigated and prosecution was directed. At court, the reporting person was declared a 'completely unreliable witness' by the judge. [redacted] PTO

Redaction of Exhibit 5 is necessary to protect the identification of staff implicated in abuse as required by Restriction Order No. 4 (see Restriction Order No. 87).

54. On more than one occasion staff witnesses informed me that they would be reluctant to report matters again, in the future, due to how they were treated within the hospital. Some expressed feelings that they had been ostracized by their colleagues and felt unsupported. When such comments were made to me, I would relay these to the management staff and/or hospital social work team.

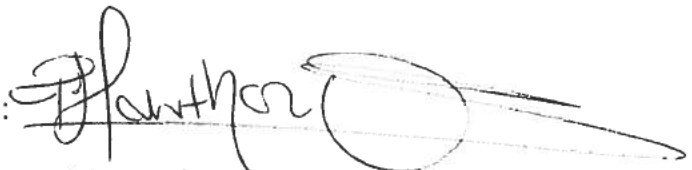
55. Where a Joint Investigation was being conducted and disciplinary proceedings were anticipated, it was requested by PSNI that the police investigation take precedence to preserve the integrity of the investigation. PSNI did not however enter into discussion as to how the staff member should be dealt with (i.e. suspended or re-positioned). Once a suspect interview had been completed, the Trust would be advised that there were no objections to disciplinary investigations progressing on the proviso that those involved (suspects and witnesses) be advised that anything that they mention in the course of the disciplinary investigation may be subject to disclosure to the courts in connection to the criminal investigation.

56. It had always been my perception that although the burden of proof in the Criminal Court is 'beyond reasonable doubt', internal disciplinary hearings had a lower threshold and the standard for disciplinary was based upon the 'balance of probabilities'. I had not been involved in any of the disciplinary hearings relating to staff. In several of my investigations (including Ennis), although the evidential standard to secure criminal convictions could not be met, there were occasions where it seemed there was compelling evidence that the Trust's Code of Conduct had been breached and, therefore, disciplinary action still feasible. I have been surprised to learn that some of the staff whom I had investigated, including the Nurse in the Ennis Investigation and HCSW

mentioned above (at paragraph 52) both of whom continued to remain employed within the hospital.

Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 11/09/24

List of Exhibits (Tracy Hawthorne)

Exhibit 1: Occurrence Enquiry Log entry dated 29/01/13

Exhibit 2: Ennis Investigation Timeline

Exhibit 3: Email to Belfast Trust outlining allegations

Exhibit 4 [RO87]

Exhibit 5 [RO87]

Occurrence enquiry log entry report

Police Service of Northern Ireland

Occurrence: **CC2012110800900 Assault @08/11/2012 17:06 DESIGNATED OFFICER REPORTED THAT DURING THE EVENING OF 07/11/12 A OUTSIDE AGENCY CARE ASSISTANT PROVIDING CARE IN THE ABOVE WARD WHEN SHE OBSERVED A NUMBER OF INCIDENTS INVOLVING PATIENTS,ALLEGEDLY AMOUNTING TO ILL-TREATMENT/COMMON ASSAULT.PPU AWARE AND DEALING AT PRESENT.FMO TO ATTEND TO EXAMINE NAMED PATIENTS FOR INJURIES AND STRATEGY DISCUSSION TO BE HELD TOMORROW MORNING AT 11:30AM.PLEASE CLOSE TO PW2299 SERIAL=900 CREATE DATE=Thu Nov 08 17:06:45 2012, CLOSING INCIDENT CODES: MAIN CODE: ASLT (ASSAULT) SUB CODE: VULA (VULNERABLE ADULT)**

Task status: **All**

Log type: **All**

Valid as of 02/09/2024 13:28:44
Printed by #56618 HAWTHORNE, T.

Occurrence	*Ref #*	*Type*	*Entry time*	*Event time*	*Author*	*Link*	*Task*
CC2012110800900		Comment	29/01/2013 15:52		#56618 HAWTHORNE, T.	No	

Log entry: Spoke with Aine Morrison who enquired whether police still wished to pursue the prospect of covert cameras being installed as this matter had not been resolved within the Trust. I advised that I did not feel that it would be appropriate at this time due to the passage of time,the increased supervision levels on the wards and lack of any further reported incidents to suggest an institutional type of abuse within the ward. I informed her that I would confirm this with my sergeant and update her accordingly.

Exhibit 2

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

Date	Circumstances	Action	Document
08/11/12 17:06	Report to police having been received that during the evening of 07/11/12 an outside agency care assistant providing care in Ennis Ward observed a number of incidents involving patients allegedly amounting to ill-treatment/common assault. FMO to attend to examine named patients and strategy discussion arranged for 11:30am on 08/11/12. Incident closed to Constable Hawthorne for investigation. Matter referred via Care Assistant's Home Manager to Muckamore Abbey Hospital Social Work Department. Detective Inspector and Detective Sergeant made aware	Incident agreed as Joint Investigation via telephone discussion with Hospital Senior Social Worker (SSW). Initial action agreed: • Forensic medical officer contacted by Police and agreed to attend hospital and examine 4 named patients. • Hospital doctor (not attached to the ward) to attend and examine remaining patients during personal care. • Police to be notified if any injuries are observed and photography to be arranged. • Pre-interview assessments to be conducted with patients – SSW to arrange trained social worker to assist.	Occurrence Enquiry Log AJP1 forms
09/11/12 11:30	Multi-agency Strategy Discussion held at Muckamore Abbey Hospital. Indications from medical staff was that it would be unlikely that any of the patients would be able to provide an account. All present agreed that the individual allegations and potential culture on the ward was of a significant concern.	• Form of words for press and families agreed • PSNI to seek outcome of FMO examinations • Hospital staff to review care records for each patient for period of one month initially and note incidents and accidents reported during that time.	Occurrence Enquiry Log VA7 – Strategy Meeting Minutes 09/11/12 as per Ennis Bundle

		• Meeting to be arranged between PSNI, medical staff and speech and language therapist to discuss possibility/viability of conducting pre-interview assessments with all patients. • Named staff members on precautionary suspension. Nurse-in-Charge moved to other duties. • Social Services to liaise with Care Provider's manager in relation to speaking to other staff who had completed duties in the ward. • Body charts to note anything of concern. • Ward Consultant Psychiatrist to be asked for statements to prove 'Mental Disorder' aspect of ill-treatment offence.	
09/11/12 14:20	Photography contacted and asked to attend hospital and photograph 3 named patients.	Hospital to seek consent from NOKs for photography.	Occurrence Enquiry Log
09/11/12 15:30	Attended workplace of Care Assistant and obtained statement.	Witness statement recorded and number of allegations were made naming 2 staff members. Also alleged Nurse-in-charge was heard to raise her voice to patients. Witness became upset during the interview, particularly when discussing witnessing a sleeping patient being pulled from a chair and onto the floor. Witness also stated that	Occurrence Enquiry Log Witness Statement HMcF

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

		she had been 'dreading' her shift on the ward, having been told by co-workers how 'horrendous' it was.	
12/11/12	Email sent to SSW,DAPO, Operations Manager, Service Manager and Detective Sergeant	Detailed account of allegations being made by Care Assistant forwarded for information purposes and not for dissemination.	Exhibit 4 – Email
14/11/12	Information received that further Bohill staff had raised concerns having witnessed incidents at MAH.		Occurrence Enquiry Log
15/12/24	Multi-agency meeting held at Muckamore Abbey Hospital.	Following actions agreed: • NIC to be suspended • Student nurse to be re-instated as no information received to suggest criminal offence/abuse. • Further Bohill staff members to be asked to provide statements. • Band 7 to be placed in monitoring role, over and above normal staff roles during day (Band 6 at night). Roles of each to be clarified. • SMT at MAH to discuss staffing levels. • Meeting to be convened with Doctor, ABE Trained Social Worker, Police and Speech and Language therapist to progress attempts to communicate with patients. • DAPO to collate staff duties and examine incident reports and body charts in an attempt to explain bruising.	VA8 – Review of Care/Protection Plan dated 15/12/24 as per Ennis Bundle Occurrence Enquiry Log

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

16/11/2012	Investigative decision recorded by DSgt McCormill	Liaison with hospital staff should be done through DAPO Aine Morrison or Esther Rafferty. All other hospital staff will step back to provide an impartial and independent investigation. Muckamore will continue to co-operate and provide information, but this should be done via the 2 aforementioned persons.	Occurrence Enquiry Log
22/11/2012	Medical Statement received from FMO however no body charts attached. Investigation update from DSgt McCormill	OEL entry indicating that DSgt McCormill had contacted DAPO and discussed 'investigative process' [referring to installation of covert cameras in Ennis Ward] and that director was reluctant to proceed until legal services had given the matter consideration. Concerns also raised about the impact on staff and management relationships. Matter to be discussed further following meeting on 28.11.12	Occurrence Enquiry Log
28/11/12	Meeting with Consultant Psychiatrist, Specialist Doctor, ward Sister, DAPO and speech and language therapist.	Indication from medical team that only one of the patients named by witnesses may be able to provide an evidential account, however this would be very basic and patient would not be able to understand the concept of attending court and providing evidence. 6 other patients within the ward identified as possibly being able to provide accounts of 'patient experience'. Speech and language input will be required to assist with facilitating communication.	Occurrence Enquiry Log dated 04/04/12

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

12/12/12	Multi-agency Strategy Discussion meeting held at Muckamore Abbey Hospital. I/O Con Hawthorne and DSgt McCormill in attendance.	• Meeting advised that 2 Care Provider staff had made allegations of a potentially and were to be spoken to by police. • Following trust interviews with Care Provider staff a further 3 staff were identified as witnessing potential offences and were also to be interviewed. • Meeting advised that police would be investigating allegations of Common Assault and Ill-treatment of a Mental Patient. • Progressing interviews with Ennis patients discussed. It was agreed that patients lacking capacity to consent would be spoken to under best interest principles, with NOK consent. • NOKs to be provided with an update on the investigation. Trust to seek permission from NOKs to share their contact details to allow police to make contact directly.	Meeting Minutes dated 12/12/12
17/12/12	Interviews with Care Provider staff	5 Care Provider staff members provided statements. References made to MAH staff already named and other MAH mentioned, although some difficulties with identification.	Statements as per file Occurrence Enquiry Log

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

20/12/12	Ennis Ward Investigation meeting – attended by DSgt McCormill and Con Hawthorne	• Summary of allegations made to date provided to those in attendance. • Plan to conduct PIAs with patients referred to. Consultations on-going. • Overview of the interviews with Care Provider staff by police shared verbally. • Update provided by DAPO that Care Provider staff have been interviewed by social services and 3 had reported concerns that were potentially of a criminal nature. • Concerns were raised that the questioning used to obtain these further disclosures may have been leading. Those present were assured that police would interview all staff disclosing potential criminal offences and that it was not felt that the police investigation had been compromised. • Trust agreed to make contact with all NOKs for patients named as potential victims and to seek permission from NOKs to have their details passed to police to allow for update to be provided. • Allegation by patient reported by brother discussed. Co-director of Nursing reported that the same patient had also made an allegation	Meeting Minutes dated 20/12/12 as per Ennis Bundle

		that she had hit her, but that she had not at any time been alone with the patient. Co-director felt it important to note the patient could make false allegations. Trust to make further enquiries to obtain more details. • Crimestoppers details shared and to be posted on the ward. Police to provide Crimestoppers leaflets for placing on ward. • Trust reviewing VA referrals and disciplinary investigations in an attempt to identify any trends. • 24hr monitoring of staff to continue. 15 Steps Challenge proposed to replace 24hr monitoring – will involve monitoring, inspection and improvements. DAPO acknowledged this as means of moving forward but felt not appropriate whilst some staff remained unidentified and poor practice had been reported. To be reviewed at next meeting. • Staffing levels discussed. It was raised that Ennis staff were feeling vulnerable and anxious about the investigation and that information was not being provided. DAPO suggested meeting with staff to explain the process. Co-director of Nursing and MAH Service Manager	

		expressed that they did not feel this was necessary.	
20/12/12	Student Nurse at MAH identified as being present on ward at time of initial allegations attended Antrim Police Station.	• Student Nurse met with I/O and DSgt and was asked whether she had observed anything of concern on the ward including abuse or rough handling of patients. She stated that she had not. Student Nurse recalled hearing one of the named patients 'rhyming' something about the HCSW [under suspension] but did not know the context. • Student Nurse stated that she was in the nurse's office most of the afternoon reading patient care plans and had not been on the floor much during the shift. • Named patient had been observed to come into day space with no clothes on and Student Nurse had encouraged her to return to her room and put clothes on. Nurse [under suspension] said she would assist with this and the Student Nurse left [the day space]. • Student Nurse stated that she did not recall seeing named patient with blood in her mouth, however phoned I/O later that date stating that upon reflection she recalled seeing a brown substance on the patient's bed, which appeared to be	Occurrence Enquiry Log Notes relating to Student Nurse, as per Exhibit 1

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

		dried blood and would have been in the area where the patient would have laid her head. Bedclothes were changed as a result. Student Nurse had thought the patient may have been chewing her mouth in her sleep or eating chocolate in bed. • Student Nurse provided a signed, written record of her shift on 7th November 2012.	
21/12/12	Email correspondence with DAPO	DAPO informed that Student Nurse had been spoken. Details of information provided shared with DAPO. Email sent by DSgt McCormill to D/Supt Ruth Smyth informing her that Trust had decided not to provide authorisation for covert cameras and were dealing with it by way of management monitoring and extra resources.	
03/01/13	Meeting with DAPO at MAH	Met with DAPO and went through information provided to police by witnesses to share allegations of a criminal nature and information that may be relevant to the Trust in relation to Care Practices. DAPO reported that she had spoken to the brother of patient who alleged she had been 'grabbed by the scruff' and brought to her room. DAPO stated that patient had indicated that this was 'done in jest'.	Occurrence Enquiry Log

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09/01/13	Meeting held with PPS Prosecutor Meeting arranged to discuss progressing PIAs	Meeting held with PPS prosecutor to discuss investigation to date and potential offences. Meeting arranged with ABE trained Social Worker and Speech and Language therapist to plan for PIAs with Ennis patients.	 Email dated 08/01/13
14 – 22/01/13	Training Course	I/O Con Hawthorne on Police Training Course	
23/01/13	Pre-interview Assessments	Con Hawthorne, Trained Social Worker and Speech and Language Therapist attempted to conduct pre-interview assessments with 3 patients deemed potentially able to engage: • **First patient** (alleged victim whose mouth was bleeding) was very distressed on arrival and initially refused to engage. Patient returned to the room and appeared distracted and was grabbing at the floor. A cup of sweets was used to try and gain attention. Patient was asked whether she had hurt her mouth. Stated that her mouth was sore and she needed a painkiller. Patient was asked whether something bad happened on the ward. Patient stated that the screens and mattress was on the floor and the blinds were down. Attempts were made again to	AJP3 Occurrence Enquiry Log

		ascertain whether patient had hurt her mouth. SALT enquired, “A long time ago, did you hurt your mouth?” Patient replied, “Aye.” Patient was asked, “What happened?” Patient then talked about bus coming and getting treats. Further attempts made to engage patient in conversation. Patient asked directly, “Do you remember the time your mouth was bleeding?” Patient did not answer. Patient deemed not able to engage and unaware of the purpose of the meeting. • **Second patient** (whose brother reported she had disclosed being grabbed by the scruff) was spoken to. Patient made reference to incidents with other patients. Patient stated that she did not wish to speak to police about any matters. Patient stated that the ward staff were very nice and she did not have any problems. • **Third Patient** (made disclosure to sister) engaged well. Also mentioned incidents with other patients and that a staff member had taken lollies from the store. Patient stated that she liked the staff. Patient was asked about telling her sister that something bad had happened to her. Patient presented as not	

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

		remembering this. No disclosures made and patient deemed unlikely to be able to provide a reliable account.	
28/01/2013	Email to DAPO requesting information	Email sent to DAPO requesting patient care plans in preparation for suspect interviews and contact details for NOKs of patients unable to engage in PIAs, should they wish to make third party statements.	Email to DAPO dated 28/01/13
29/01/2013	Attempt made to contact solicitor to arrange suspect interviews.	Solicitor not available. Message left requesting he contact me back.	Occurrence Enquiry Log
	Contact with patient's brother re: third party report	Brother of patient who had alleged she had been 'grabbed by the scruff' spoken to and offered opportunity to provide a third party statement in light of patient not being able to provide any evidence in relation to this. Brother stated that he had spoken to patient, who dismissed this and stated that the staff member had not touched her and may have been joking. Brother declined to make a statement in light of this.	Occurrence Enquiry Log
	Email to DAPO	Email to DAPO stating that patient's brother had been spoken to and does not wish to make third party complaint.	Email to DAPO dated 29/01/13

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

	Telephone Contact with DAPO	Spoke with DAPO who enquired whether police still wished to pursue having covert cameras installed, stating that this had not as yet been resolved within the Trust. I/O expressed that due to passage of time, increased supervision on the ward and lack of further incidents suggesting institutional abuse, it may not be appropriate. DAPO informed that DSgt would be made aware of query and DAPO would be updated accordingly.	Occurrence Enquiry Log
01/02/13	Solicitor contacted to arrange suspect interview Attempted contact with patient's brother Suspect (Nurse) contacted	Solicitor spoken to and he stated that he did not have information to make arrangements for interview. Agreed to call I/O back. Attempted to contact patient's brother re: third party statement. No answer. Message left. Suspect contacted and informed that solicitor had been spoken to and was to make contact with her to arrange attendance for interview.	Occurrence Enquiry Log
04/02/13	Email request to DAPO	Further request sent to DAPO for patient behavioural support plans/ care plans	Email to DAPO dated 04/02/13
06/02/13	Suspect (Nurse) contact		

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

		Suspect spoken to and stated that she was willing to attend the station on a voluntary basis for interview even though her solicitor was not currently available. Agreed to attend station at 13:00 on 08/02/13	Occurrence Enquiry Log
07/02/13	Suspect (HCSW) contacted	Suspect stated that she had been advised to have solicitor present for interview, although contemplated attending without legal representation. Nature of investigation explained. Suspect expressed it may be best to have solicitor present. Stated she was aware he was going on a period of leave. Suspect to contact solicitor and make arrangements to attend w/c 18/02/13	Occurrence Enquiry Log
	Third Party Statements from brother and sister-in-law of patient (with bleeding mouth)	I/O attended the home address of brother and sister-in-law of patient who had presented with bleeding to the mouth and had made a verbal allegation against HCSW. Statements recorded. Brother stated he had been made aware that his sister had allegedly been assaulted by a staff member. He attended the hospital (along with his wife). He met with the service manager, who informed him about the investigation. He stated at no point did the Service Manager name any of the staff involved in the investigation. Witness asked his sister, "What happened to you? You've got a sore mouth. Did anyone hit you?" She said,	Occurrence Enquiry Log Witness Statements

		"[HCSW] hit me." She said, "She hit me in the face and I hit her back." She said, "[HCSW] was crying and went home." Patient seemed agitated and excited while she was saying it, rocking in her seat and wringing her hands. She kept repeating this and said something like, "[HCSW]'s bold, she'll not be going to the Christmas Party. She was naughty." She repeated this a few times and then went on to talk about other people in the ward, mentioning names, but she did not make any allegations. Witness stated he had never known his sister to make any remarks like that before about staff. Witness's wife corroborated this account. Form 81 Request for Care Plans hand-delivered to Data Protection Office, Knockbracken.	
	Form 81 Request for Care Plans		Occurrence Enquiry Log
20/02/13	Suspect Interview (HCSW) conducted by DSgt McCormill	HCSW attended Antrim Police Station on a Voluntary basis accompanied by her legal representative to be interviewed in relation to the following offences, which allegedly occurred in Ennis Ward, Muckamore Abbey Hospital: • Common Assault and Ill Treatment of a Patient with a Mental Disorder on 09/10/12 - belt fastened tightly, patient walked to the door and put	Case File C13011914 Interview Summary

		outside the fire door by both suspects. • Ill treatment of a patient with a Mental Disorder on 09/10/12 - patient left to sit outside without appropriate protective clothing on.(Both suspects) • Common Assault and Ill Treatment of a Patient with a Mental Disorder on 07/11/12 - patient pulled from the sofa and onto the floor. • Assault Occasioning Actual Bodily Harm and Ill treatment of a Patient with a Mental Disorder on 07/11/12 – patient alleged that she had been hit by HCSW and was seen to have blood coming from her mouth. During the interview HCSW denied all of the allegations, stating that she was very fond of the patients.	
28/02/13	Suspect interview (Nurse)	Nurse attended Antrim PSNI Station on a voluntary basis, accompanied by her solicitor, to be interviewed in relation to the following offences, which allegedly occurred in Ennis Ward,Muckamore Abbey Hospital: • Common Assault and Ill Treatment of a Patient with a Mental Disorder on 09/10/12 – patient's belt fastened tightly, walked to the door and put outside the fire door.	Case File C13011914 Interview Summary

		• Common Assault and Ill Treatment of a Patient with a Mental Disorder on 09/10/12 - patient - grabbed by the jumper at the chest and told, "Get the fuck out of my face." And/or either, "This is doing my head in." Or, "She's fucking doing my head in." Then pulled across the room and pushed onto a sofa. • Ill treatment of a patient with a Mental Disorder on 09/10/12 - patient left to sit outside without appropriate protective clothing on.(Both suspects) • Common Assault and Ill Treatment of a Patient with a Mental Disorder on 05/11/12 – Patient unkown- Staff Nurse witnessed patient being pushed onto a chair by the 'night nurse'. • Common Assault and Ill Treatment of a Patient with a Mental Disorder on 07/11/12 - patient**-** blood wiped roughly from her mouth using a personal hygiene mitt. • Ill Treatment of a Patient with a Mental Disorder on 07/11/12 - failed to intervene when patient was being assaulted by fellow peer and encouraged her to hit back. • Common Assault and Ill Treatment of a Patient with a Mental Disorder on 07/11/12 – patient pushed into a chair, causing her to hit her head off the back of the chair.	

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

		During the interview the suspect denied all of the allegations, stating that staff would not do those things. For some of the offences, she denied that she was the staff member involved, despite the descriptions given matching hers and staff rota confirming she was on duty.	
07/03/13	Case File opened	Case file assembly commenced	Occurrence Enquiry Log Niche
19/03/13	Form 1 submission to PPS to protect Statute Barred Offences	Form 1 request sent to PPS advising due to the nature of this investigation, the vulnerable adult victims and the large number of allegations forthcoming from several different witnesses, the investigation has been protracted and as a result the first reported incidents of Common Assault will be statute barred on 09/04/13. Form 1 is requested to ensure that these offences can be pursued.	Niche Case File C13011914
26/03/13	Case file assembly	Documents attached. Case file for checking by I/O and submission via supervisor.	Occurrence Enquiry Log Niche
27/03/13	Full file submitted to PPS	File submitted to PPS recommending prosecution of both staff members.	Niche tasks Case File C13011914
29/03/13	Multi-agency Meeting attended by Con Hawthorne	Informed meeting that case file had been submitted recommending prosecution of the two named staff. Explained No Prosecution had been recommended in relation to	Minutes of meeting dated 28.03.13 Police Report Exhibit 5

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

		patient bleeding from mouth (due to potential that this may have been as a result of an abscess). Service Manager provided with comprehensive account of investigation (based on Outline of Case submitted to PPS). I/O agreed to updated NOKs of patient-victims where prosecution was being recommended.	
03/10/13	Prosecutorial Decision issued by PPS	PPS issued prosecutorial decision in relation to Nurse. Prosecution directed for Ill-treatment and Common Assault (no prosecution directed on one count of Common Assault) PPS issued prosecutorial decision in relation to HCSW. Prosecution directed prosecution for Ill-treatment and Common Assault (No prosecution directed on 1 x Common Assault)	Niche Case File C13011914
14/11/13	NOK updates	NOKs contacted and made aware of PPS decision to prosecute.	Occurrence Enquiry Log
01/04/14	Case for mention	Case mentioned at Antrim Magistrate's Court. Further material being requested by defence.	Niche - Court Result Meeting minutes dated 08.04.14

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

08/04/14	Multi-agency Meeting attended by Constable Hawthorne	Meeting updated that case was in court and had been further adjourned with no date fixed Impact of the Investigation discussed. DAPO and Service Manager reported that staff had been 'upset and angry' about not having been made aware of the allegations. DAPO stated that she had the sense that staff did not believe the allegations or that the Service Provider staff were unable to identify some of the MAH staff. Police raised concerns about MAH staff attitude, if they deemed allegations made by Care Provider staff were not of concern. Those present were informed that the Joint Protocol Adult Safeguarding Investigation was now closed.	Minutes of Meeting dated 08/04/14 Ennis Bundle – pg 80
20/11/14	Contest – Antrim Magistrate's Court	HCSW was found guilty of common assault on a female patient. She was acquitted of three counts of ill-treatment of a mental patient and another charge of assault against the same patient. Nurse was acquitted of all five counts of ill-treating a patient and two of common assault.	Niche – court results

Timeline of Events – Police Investigation – Ennis Ward, Muckamore Abbey Hospital 2012

RO87 [redacted]			
16/12/14	Sentencing of HCSW	HCSW sentenced at Antrim Magistrate's Court for 1 x Common Assault to 2 months imprisonment suspended for 2 years. Bail granted for appeal.	Niche – Court result
03/02/15	Appeal Hearing for HCSW	Appeal heard at Coleraine Crown Court for 1 x Common Assault. Nurse attended as witness for the defence. Conviction and Order reversed.	Niche – Court result

Exhibit 3

HAWTHORNE Tracy

From: HAWTHORNE Tracy
Sent: 12 November 2012 11:26
To: H92 '; 'aine.morrison@belfasttrust.hscni.net'; 'esther.rafferty@belfasttrust.hscni.net'
Cc: 'Mills, Barry'; MCCORMILL Elaine
Subject: 1.NOT PROTECTIVELY MARKED-All Networks:: SOE Bowhill staff member - FOR INFORMATION NOT DISSEMINATION

Below is for information only and not for disemmination at this time.

Sgt McCormill and I met with B2 on Friday afternoon in relation to the incidents in Ennis Ward.

She alleged that she had arrived on the ward at 11am and went to find the charge nurse, H198 H198 asked her to wait in the office and after about 10 minutes brought her down to the dayroom. She stated that she was in the dayroom along with another staff member who had been brought in from another ward and did not know the patients. She could not recall this staff member's name, but stated that she was pleasant (no allegations made against this staff member).

She stated that she had not been given an induction or made aware of the patients and their needs/behaviour managements plans. She had not been provided with a key or a personal alarm. On her way into the dayroom she met H197 who said she was going to the toilet and would be back soon. B2 stated that she was left with the patients for approximately 20 minutes and patients became agitated and she herself was assaulted and had no means of obtaining assistance.

P39 had also got faeces on her hand and B2 had no means of cleaning this or gaining access to the bathroom and had to sit holding P39 wrist to prevent her from putting her hand near her mouth. When H197 returned after approximately 20 minutes, B2 asked if she could change P39 She was given a key. She asked where the pads were kept and was informed they were in a cupboard. P39 clothes had also been soiled. B2 did not know where P39 bedroom was and stood at the door of the bathroom shouting for assistance and asking for help for about 10 minutes before the other care assistant came and fetched clothes for P39

B2 returned to the ward with P39 and stated that H197 was being rough with P39 grabbing the band of her trousers, turning her and pushing her away,pulling her back by the band of her trousers on a few occasions when P39 stumbled. H197 told P39 that if she did not stop stripping, she would not be allowed any lunch. B2 tried to put P39 clothes back on. H197 had told her that if she continued doing that, she would do it all day and advised B2 not to be face on to P39 and to turn her away by the band of her trousers.

At lunchtime there are different sittings for patients and B2 alleged that she had been left alone in the dayroom with 2 patients (P39 and P41 while other staff were in the dining room. B2 then brought P39 to the dining room for her lunch and on her way through met H159 who entered the dayroom shouting something like, "Would you behave, that's enough." H197 asked B2 to feed P39 her lunch, which she did.

After B2 lunch break, she returned around 2pm. H197 had moved to the top part of the ward, leaving H159 and another Care Assistant (which she stated was possibly named H869 in the bottom dayroom. B2 asked if it would be okay to read the patient care plans, which she then did in the nurse's office. She stated that H198 got her the care plans and H198 had been in and out of the office while she was there reading them.

At 15:30 B2 had a break and went outside to get a smoke. As she passed the dayroom she noticed the patients were there alone. H869 H159 and H205 were in the dining room with a patient named P22 After her break she returned to the nurse's office and stayed there until about 17:30. She had a break in the cafe from around 17:30 to 18:00.

On her return H198 asked B2 if she minded putting laundry away and getting the patients ready for bed. B2 was left to supervise in the dayroom while H197 H159 and a student nurse were down towards the bathroom

area (which cannot be seen from the dayroom). B2 then heard shouting and walked to the top of the dayroom and saw P40 running from the direction of the bathroom naked. She hit two patient, P597 and P598 as she passed them and kicked and thumped patients in the dayroom, while shouting, "I hate H159 She hit me." There was blood in her mouth across her teeth and the blood started to dribble down her chin." No staff came out after P40 and B2 tried to settle her. She asked her if she would get dressed for her and she said 'No' and kept repeating that H159 had hit her.

B2 then went down to the bathroom, where H197 and the student nurse were with two patients. She asked if they could help her settle P40. She stated that they both ignored her. She then said P40 was hitting other patients and they said, "Okay we'll come now." The student nurse came down and spoke with P40, telling her that if she did not get dressed, shoe would not get any sweets or lemonade.

H197 then came in with a mitt used for personal hygiene crumpled up in her hand and roughly wiped P40 mouth, as P40 tried pulling her head away and repeating that she hated H159 and that she had hit her.

At approximately 19:00 H159 asked B2 if she wanted to go for a smoke. As they walked into the dayroom P39 was lying sleeping on the sofa, facing the back of the chair and in the foetal position. There were no other staff in the room. Without speaking to P39 H159 put her two hands into the waistband of P39 trousers and pulled her off the sofa. P39 landed on the floor on her back and was startled awake. Then H159 said to B2 'sort of laughing' "I wouldn't like to be wakened from my sleep." She then walked out,leaving P39 lying on the floor and did not stop to check her.

B2 went out for a smoke, feeling intimidated by staff. During this time, she said that H159 did not mention any incidents, just stated that B2 must have found her rude when she did not introduce herself when she first came into the ward.

After getting P39 supper and ready for bed, B2 returned to the dayroom, where H197 was there along with other patients. P41 became agitated and was hitting out at residents and staff. She was 'going' for H197 who protected herself with her forearm. P41 kicked P597 and hit P599 on the head. P22 had been lying on the sofa and P41 then sat on top of P22 hip, crossing her legs and bouncing up and down. P22 indicated that she was upset. H197 told her to 'stop being a big softie and hit her back.'

H197 then pulled P41 into a standing position and 'shoved,nudge and pushed' P41 towards her chair at the other end of the dayroom. H197 then shoved P41 into her chair, pushing her around the shoulder area and B2 heard an audible 'thud' where P41 head hit the back of the chair. P41 got up immediately and started hitting out again at H197 P41 went to P597 and hit her and P597 kicked her back. H197 remarked that P597 wouldn't be soft with P41

At around 8pm H869 came to the ward and sat with P41 talking to her and holding her hands until she settled.

While B2 had been in the office, she had heard H198 raise her voice at patients, saying, "I've had enough of your behaviour." She did not feel comfortable about approaching any of the staff about her concerns and phoned her team leader on her way back from Muckamore to Coleraine.

B2 had become upset during interview, particularly when she spoke about the incident where P39 was pulled from the chair. She also stated that she had been dreading her duty in Ennis Ward, having been told by other Bowhill staff about how horrendous it was.

Tracy Hawthorne
Adult Protection Officer
PPU,Antrim
tel:94481645

Redaction of Exhibit 4 is necessary to protect the identification of staff implicated in abuse as required by Restriction Order No. 4 (see Restriction Order No. 87).

Redaction of Exhibit 4 is necessary to protect the identification of staff implicated in abuse as required by Restriction Order No. 4 (see Restriction Order No. 87).

Redaction of Exhibit 4 is necessary to protect the identification of staff implicated in abuse as required by Restriction Order No. 4 (see Restriction Order No. 87).

Redaction of Exhibit 5 is necessary to protect the identification of staff implicated in abuse as required by Restriction Order No. 4 (see Restriction Order No. 87).