

PUBLIC INQUIRY MUCKAMORE ABBEY HOSPITAL

TERMS OF REFERENCE

Core objectives

1. The core objectives of the Inquiry are to:
 - a. examine the issue of abuse of patients at Muckamore Abbey Hospital (MAH);
 - b. determine why the abuse happened and the range of circumstances that allowed it to happen;
 - c. ensure that such abuse does not occur again at MAH or any other institution providing similar services in Northern Ireland.

Timeframe

2. The Inquiry will report and make findings on events that occurred between 2nd December 1999 and 14th June 2021.
3. The Inquiry will be able to receive and take account of evidence outside of that period where such evidence will assist the Inquiry in examining, understanding and reporting on matters within these terms of reference.

What occurred?

4. The Inquiry will examine the nature and extent of abuse of patients at MAH.
5. The term “abuse” may include (but is not restricted to) the following:
 - a. physical abuse;
 - b. sexual abuse;
 - c. psychological abuse;
 - d. mental or emotional abuse;
 - e. patient neglect;
 - f. inappropriate or negligent care;
 - g. appropriation of or improper interference with patients’ finances or belongings;
 - h. other misbehaviour towards patients.
6. The Inquiry will examine the role of frontline staff, those with responsibility for clinical and professional oversight, those with leadership and/ or management

responsibilities within the relevant Health Trusts (and any other relevant persons or bodies)¹ in respect of such abuse.

7. The Inquiry will also consider, to the extent necessary to enable the Inquiry to examine the nature and extent of abuse of patients, the adherence by staff and management, the Trusts, the Board and the Department of Health to relevant statutory obligations, the regulatory framework, protocols, policies and guidance in respect of all aspects of service delivery.
8. The Inquiry will examine the primary and secondary causes of such abuse and will address the question of whether the abuse resulted from systemic failings within MAH or the wider health care system in Northern Ireland.

Recruitment, retention, training and support

9. The Inquiry will examine the policies and practices relating to recruitment, retention, training and support of staff and management at all levels within MAH (and, where necessary, within other facilities offering comparable services).

Identifying and responding to concerns

10. The Inquiry will examine the adequacy of methods available to communicate concerns (including allegations of abuse) by staff, patients, relatives and others about the treatment of patients at MAH.
11. The Inquiry will examine the response to such concerns by frontline staff, those with responsibility for clinical and professional oversight and those with leadership and/ or management responsibilities within the relevant Health Trusts, the Health and Social Care Board, the Public Health Agency and the Department of Health.
12. The Inquiry will examine the operation of all relevant commissioning, supervisory and regulatory agencies (including but not limited to those agencies specified in paragraph 11) to determine whether and if so why there were failures in the early identification, investigation and resolution of issues raised about the treatment of patients.
13. The Inquiry will also examine the response of other relevant agencies, including the Police Service for Northern Ireland (PSNI), the Patient and Client Council (PCC), the Health and Safety Executive (HSE) and the Regulation and Quality Improvement Authority (RQIA), when allegations of abuse of patients at MAH were reported to them.

¹ Note that all references in this document to the Health Trusts and other bodies with roles and responsibilities in respect of health and social care shall include any precursors of such bodies that existed within the timeframe of these terms of reference.

CCTV

14. The Inquiry will examine the effects of instalment, operation and use of CCTV at MAH.

Safeguards, mechanisms and policies regarding other patients

15. The Inquiry will examine the safeguards, mechanisms and policies in place to ensure that patients were not subject to abuse or other disturbing behaviour by other residents/patients and whether those controls and policies were sufficient.

Resettlement

16. The Inquiry will examine the adequacy and workings of the policy and process of discharge and resettlement of patients of MAH.

Resources

17. The Inquiry will consider the adequacy of financial resources to ensure:
 - a. appropriate numbers, skills, quality and training of staff;
 - b. appropriate care, treatment and accommodation for patients with mental health conditions and/or learning disabilities treated or cared for at MAH.

Legal and regulatory framework

18. The Inquiry will examine the following:
 - a. the relevant primary and secondary legislation;
 - b. the regulatory framework;
 - c. any relevant Codes, policies, guidelines, reports and other documentation relating to management, administration and working practice at MAH (and, where necessary, of other comparable facilities).
19. The Inquiry will consider the adequacy of the above to provide a framework to prevent abuse of patients with mental health conditions or learning disability in MAH and other such settings in Northern Ireland.

Matters of practice and procedure

20. The Inquiry Chair will determine how the Inquiry is conducted, including the procedure, the nature of evidence and calling of witnesses to the Inquiry.
21. Aspects of practice and procedure may be governed by protocols to be established at the outset of the Inquiry.
22. Appropriate witness services will be made available in the course of the Inquiry.

Report and recommendations

23. The Inquiry will submit its report to the Minister of Health. The Inquiry may make findings on matters within the terms of reference as outlined above, including the issue of abuse and whether such abuse resulted from systemic failings.
24. Having regard to (and dependent on) those findings, the Inquiry will make recommendations in respect of the following:
 - a. the core objective of ensuring that any such abuse and any such failings do not recur at MAH or at any other facility providing similar services in Northern Ireland;
 - b. improvement of the training of staff and management at MAH and comparable facilities;
 - c. improvement of management, policies, systems and processes within MAH, including those relating to whistleblowing and corporate governance;
 - d. improvement of competence, quality and internal governance of the Board of such hospitals;
 - e. to the extent that it is necessary and appropriate, the role of wider adult social care services and the relevant health and social care bodies (including but not limited to the Health and Social Care Trusts, the Health and Social Care Board, the Public Health Agency and the Department) in ensuring the safety of patients and best practice in service delivery at MAH and comparable facilities;
 - f. the legal and regulatory framework and related matters;
 - g. the requirement or desirability of the provision of redress to meet the particular needs of victims of abuse within MAH.
25. The Inquiry Chair may, if necessary and appropriate, issue an interim report or reports with recommendations.