

PRIVATE & CONFIDENTIAL

MUCKAMORE ABBEY HOSPITAL INQUIRY
SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL
ON MONDAY, 13TH JUNE 2022 - DAY 5

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I N D E X

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SUBMISSION BY MS. ANYADIKE-DANES 6

1 THE INQUIRY RESUMED ON MONDAY, 13TH JUNE 2022 AS
2 FOLLOWS:

3
4 CHAIRMAN: Morning. Thank you. Good morning,
5 Mr. Doran. 10:01

6 MR. DORAN: Good morning. Today the Panel will be
7 hearing a further opening statement. In a few moments
8 Moyne Anyadike-Danes QC will speak on behalf of Core
9 Participants affiliated to The Society of Parents and
10 Friends of Muckamore Abbey, and also on behalf Core 10:01
11 Participants affiliated to Action for Muckamore.

12
13 The Panel will then go into closed session this
14 afternoon for viewing of CCTV footage, and that viewing
15 is scheduled to take place on Monday to Thursday of 10:01
16 this week. The Inquiry is not sitting on Friday and is
17 not sitting next week.

18
19 Oral evidence is then due to commence on Tuesday, 28th
20 June, and a schedule for the oral evidence will be 10:02
21 issued later this week.

22
23 Just before today's opening statement, I want to
24 clarify one matter arising from last week's hearings,
25 and that relates to the solicitor representation of the 10:02
26 various Core Participant public authorities.

27
28 Just to clarify, the Department of Health is
29 represented by the Departmental Solicitor's Office or

1 DSO; the Belfast Trust is represented by the
2 Directorate of Legal Services or DLS; and the RQIA is
3 represented by a separate solicitor representative
4 within the DLS. So, I just wanted to clarify that
5 matter before we commence this morning.

10:03

6 CHAIRMAN: I think I may have got that wrong as well,
7 so I'm grateful for the clarification.

8 MR. DORAN: Thank you, Chair.

9 CHAIRMAN: Yes. Thank you. Ms. Anyadike-Danes.

10

10:03

11 SUBMISSION BY MS. ANYADIKE-DANES

12

13 MS. ANYADIKE-DANES: Thank you. Things fall apart.
14 The centre cannot hold. For decades Muckamore Abbey
15 Hospital was the centre for the assessment and
16 treatment of severe learning disabilities and mental
17 health needs in Northern Ireland. It did not hold. As
18 a result, hundreds of vulnerable people and their
19 families were harmed and were deprived of the chance to
20 live their best lives.

10:03

10:04

21

22 Alternatively, and aptly put by Mr. Aiken for the
23 Belfast Health and Social Care Trust, a system relies
24 on people, it relies on people to do the right thing at
25 the right time, and when that does not happen then the
26 system will fail. For my clients, the system did fail
27 and their loved ones were abused.

10:04

28

29 So my name is Moyne Anyadike-Danes QC, I'm instructed

1 by Claire McKeegan of Phoenix Law and I'm assisted by
2 my junior counsel, Helena Wilson and Steven McQuitty.
3 It is our privilege to assist our clients in this
4 public inquiry which has, as its core objective,
5 examining the abuse that occurred, why it happened, how 10:04
6 it was allowed to happen, and what needs to be done to
7 ensure it does not happen again in Northern Ireland.
8 We are very grateful to the Inquiry for this
9 opportunity to make an opening statement and for the
10 assistance of the Inquiry team in getting us all to 10:05
11 this stage.

12
13 I want to say something about the individual clients.
14 We act on behalf of 32 clients, all of whom are
15 associated with Muckamore Abbey Hospital. I'm going to 10:05
16 call that "Muckamore".

17
18 That association encompasses the loved ones of our
19 clients who were patients in Muckamore, loved ones who
20 died in Muckamore, those who returned home to be cared 10:05
21 for by their families, those placed in supported
22 living, and at least one family member who was
23 transferred to a facility in England where he remains.
24 It also encompasses those who have been deemed
25 medically fit for discharge but have no alternative but 10:05
26 to remain in Muckamore as no appropriate placement has
27 been provided. As well as those who now consider
28 Muckamore their home, having been there so long and
29 expect to live out their days there.

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without exception all of them suffered abuse, whether sexual, physical, emotional or financial. Some of this is captured on CCTV and we understand forms part of the PSNI's Operation Turnstone. Other abuse were the subject of complaint and may be involved in what Mr. Robinson for the PSNI referred to in his opening as the previous responses to complaints and previous investigations.

10:06

We also represent those trainees who went to Muckamore for training and work experience. They will give evidence as to what they saw and the impact it made on them. Suffice it to say that so far as they are concerned it did not reflect the values of the Belfast Trust to which Mr. Aiken referred to in his opening.

10:06

10:06

I'll say something about those experiences later, and of course the detail will be the subject matter of their evidence to this Inquiry. Nevertheless at this stage it is worth noting that the collective experience of our clients with Muckamore spans from 1950 to this present day, a period of 72 years, which is very nearly the entire life of Muckamore itself. We have clients whose loved ones were admitted as children, a practice that continued until 2010 when the services provided in Muckamore's Mallow Unit were replaced by the newly opened Iveagh Centre.

10:06

10:07

1 we also have clients who had their loved ones admitted
2 on a voluntary basis, believing - because that's what
3 they were told - that they would be assessed, diagnosed
4 and then discharged with a treatment plan to help them,
5 but instead they ended up being detained and staying 10:07
6 far longer. In some cases for decades. Together, the
7 experiences of our clients span the decades and covers
8 the wards with which the Inquiry's investigation is
9 likely to be most concerned, including the now infamous
10 Psychiatric Intensive Care Unit, or PICU, and the 10:08
11 seclusion room.

12
13 The Chairman and senior counsel for the Inquiry
14 referred to The Society of Parents and Friends of
15 Muckamore Abbey Hospital and the Action for Muckamore. 10:08
16 Our clients that are associated with those two
17 organisations are either Core Participants in this
18 Inquiry already or are in the process of applying for
19 this status, and I want to say something about those
20 two organisations. 10:08

21
22 The Society of Parents and Friends of Muckamore Abbey
23 Hospital was formed in 1962. The main purpose being to
24 safeguard the wellbeing of patients through enhancing
25 the quality of their lives by, where possible, becoming 10:08
26 involved in their social, health and educational
27 pursuits. An important part of their activities was to
28 raise funds for projects and these funds financed the
29 construction of the on-site swimming pool, the

1 community centre, known as Cosy Corner, the
2 multisensory rooms and a distance learning centre.

3
4 The funds raised also were used to provide for other
5 amenities, such as the provision of bicycles and 10:09
6 tricycles, and to fund holidays, patients' outings, as
7 well as Easter and Christmas parties. The Society also
8 provided a platform for family carers to come together
9 and network so they could meet other carers and benefit
10 from the sharing of experiences, both good and bad. 10:09
11 Over the years, the Society's fundraising role has
12 given way to something far more essential to those
13 associated with Muckamore: campaigning, advocating and
14 protecting the rights of those who remain in Muckamore
15 and their families. 10:09

16
17 In the years since the initiation of the Muckamore
18 Resettlement Programme, which followed the publication
19 of the Regional Strategy For Health and wellbeing,
20 which covered a span of 1997 to 2002, the Society has 10:09
21 found itself necessary to become involved in the
22 planning and progression of this programme. This has
23 involved sitting in the Intertrust Resettlement Group
24 and the Health and Social Care Board Resettlement
25 Group, as a means of acquiring important information 10:10
26 for patients and carers. The Society has also had to
27 forge links with the ever-changing senior management
28 within Muckamore, not to pursue its aim of highlighting
29 issues and concerns raised by patients and carers, but

1 also to obtain feedback that it proved so difficult for
2 individual families to acquire.

3
4 So that's the Society. And now for Action for
5 Muckamore, or AFM as it is sometimes called. 10:10

6
7 It was formed in early 2018, just as the fallout of the
8 scandal was breaking in the media, and it was formed by
9 one affected mother who is a Core Participant and a
10 client. She had been troubled by care in Muckamore due 10:10
11 to longstanding concerns arising from the neglect of
12 her son, and she spoke to several parents and they
13 wanted answers as well and they wanted them without
14 further delay, and they needed support, and together
15 they formed AFM. The group which started with a 10:11
16 handful of affected parents quickly grew to over 30
17 families over the course of the campaign. Members of
18 AFM still have ongoing issues with the neglect of their
19 loved ones, short staffing, abuse and overmedicating,
20 and many of them still have outstanding serious adverse 10:11
21 incident investigations. They are clear that these
22 issues are current and ongoing. So far as they're
23 concerned their loved ones remain at risk and in an
24 unsafe and inappropriate environment.

25 10:11
26 The core aims and objectives of AFM were, from the
27 outset, to raise awareness of the abuse scandal at
28 Muckamore and to demand answers and accountability.
29 They assist distressed families by flagging services to

1 them, sharing information on managing bureaucratic
2 processes from their own experience, and have grown to
3 a significant combined voice, and it was through the
4 sharing of their stories that families began to see
5 patterns in the abuse and that it was on a much greater 10:12
6 scale than they could ever have conceived of just as
7 individuals.

8
9 AFM has worked closely with local media and they're
10 grateful for the interest shown and the cover given to 10:12
11 the abuse that is their cause.

12
13 AFM instructed Phoenix Law in and around December 2018
14 to assist them with their campaign strategy and the
15 ongoing call for a full statutory inquiry. They 10:12
16 commenced two separate judicial reviews over the course
17 of their campaign to try and compel a public inquiry,
18 although we're here now it has to be remembered we
19 weren't always here willingly.

20 10:13
21 In 2020 AFM launched a petition and gathered thousands
22 of signatures in public support of their quest for
23 trail, and they were also instrumental in lobbying
24 politicians and in securing support from all five
25 leaders of the main political parties for a public 10:13
26 inquiry, and together the Society and AFM have been
27 instrumental in securing this Inquiry and in providing
28 mutual support for families sharing information and
29 holding the authorities to account. However, they do

1 not consider that the commencement of this Inquiry
2 marks the end of their own work, and they remain
3 committed to continuing the fight for justice for those
4 abused in Muckamore, whether it occurred fifty years
5 ago, five months ago, or even five days ago. 10:13

6
7 So now I want to say something about the structure of
8 this opening. This opening comprises of four sections.
9 What I was just dealing with there is essentially the
10 clients, the people that have brought me there. The 10:14
11 four sections are entitled the betrayal, the silenced,
12 a culture of impunity, and the response. So let me say
13 something about the betrayal.

14
15 Our clients expected that when their loved ones were 10:14
16 admitted to Muckamore, especially when they were
17 encouraged to take them there voluntarily, that they
18 would be treated professionally, with care and that
19 their dignity would be respected and that they would be
20 kept safe from themselves - which was sometimes 10:14
21 necessary - and from other patients. In short, they
22 trusted the Trust to look after their loved ones.

23
24 This section deals with the source of those
25 expectations. Where does it come from? Why do people 10:15
26 think that's what will happen when they put their loved
27 ones in an institution like Muckamore? And what our
28 clients regard as a betrayal of their trust, which is a
29 view shared by the current Chief Executive of the

1 Trust, Dr. Cathy Jack, not alone in feeling that trust
2 was betrayed.

3
4 Up until the 1990s, individuals with learning
5 disabilities and mental health needs were, as described 10:15
6 by Dr. Pauline Morris in her study "Put Away A
7 Sociological Study of Institutions for the Mentally
8 Retarded", literally they were put away in
9 institutions.

10
11 There they were largely out of sight of society with
12 little focus on treating, educating or rehabilitating
13 them, with limited checks and balance on their care.
14 Muckamore opened in that era with part of its site
15 being developed in 1958 as a special care colony. 10:16
16 That's what it was called, a "colony". Some of our
17 clients' loved ones were admitted to Muckamore during
18 that era. Except for one who died after 20 years, the
19 others stayed in Muckamore for nearly 50 years, with
20 two of them having been admitted when they were only 10:16
21 three years old.

22
23 The objective, since the 1970s, has been that
24 Muckamore, and hospitals like it, should not be the
25 home of patients, that adequate provision should be 10:16
26 made in the community for specialist local placements
27 near families. Where hospital care is provided, it
28 should be for emergency situations only and not on a
29 long-term basis. The care of any vulnerable adult

1 should be delivered with compassion, kindness and in a
2 safe manner. This objective was reiterated by
3 Mr. Andrew McGuinness in his opening for the Department
4 of Health.

5
6 So, what are the legal and policy standards that gave
7 rise to the expectation that my clients had? In 1975,
8 the general assemble of the United Nations made the
9 declaration on the rights of the disabled person, which
10 provides that disabled persons have the right to live 10:17
11 with their families and to participate in all social,
12 creative and recreational activities. It goes on to
13 state that:

14
15 "If the stay of a disabled person in a specialist 10:17
16 establishment is unavoidable then that environment and
17 the living conditions should be as close as possible to
18 those of the normal life of a person of his or her
19 age."

20
21 That's what it says. In 1995 the Department published 10:17
22 a paper entitled "Review of policy for people with a
23 learning disability", which stated that the aim of
24 government policy for people with a learning disability
25 should be inclusion. Inclusion in society, inclusion 10:17
26 in decision-making, participation so far as is
27 practicable in mainstream education, employment and
28 leisure, integration in living accommodation, and the
29 use of services and facilities, not least in the field

1 of health and personal social services. To give effect
2 to that, in 2002 the Department commissioned a
3 comprehensive independent review of the law, policy and
4 provision affecting people with mental health needs or
5 a learning disability in Northern Ireland, and under 10:18
6 the Chairmanship of Prof. Bamford, the Terms of
7 Reference emphasised the personal dignity and human
8 rights of people with learning disabilities and was to
9 be based on the evidence based best practice standards.
10 The central vision was stated as "a valuing of people 10:18
11 with mental health needs or a learning disability".
12 Their rights to full citizenship, equality of
13 opportunity and self-determination.

14
15 As part of the Bamford Review, in 2005 the Department 10:19
16 published a report entitled "Equal Lives: Review of
17 policy and services for people with a learning
18 disability in Northern Ireland". This was informed by
19 the themes of citizenship, social inclusion,
20 empowerment, cooperation and individual support. The 10:19
21 report sets out 12 equal lives objectives for service
22 provision policy, including that those with a learning
23 disability should have their home in the community,
24 provision of locally based services to be near
25 families. That people with learning disability are to 10:19
26 have control over their lives through person-centred
27 approaches, and that health and social care staff
28 should be competent.

29

1 Importantly, the report noted that:

2
3 "1. A significant proportion of adult admissions to
4 specialist learning disability hospitals are people
5 with a mild/moderate learning disability. Many of these
6 admissions could be prevented if appropriate
7 Community supports were in place.

8
9 2. A low level of community provision for adults with
10 dual diagnoses of learning disability and mental 10:20
11 ill-health lead to an overdependence on hospital based
12 interventions.

13
14 3. Guidance was needed on legal, human rights and
15 practical issues for managing challenging behaviour." 10:20
16

17 well, the UK ratified the UN Convention on the Rights
18 of Persons with Disabilities in 2009. This Convention
19 emphasised that persons with disabilities are
20 rights-holders. In their own right they hold rights - 10:20
21 not just people on behalf of them, they hold their own
22 rights - and set out protections from discrimination
23 and significantly provided for supported
24 decision-making to assist persons with disabilities to
25 exercise their full capacity. 10:21
26

27 So let's look a little now at health legislation. From
28 1987, as set out in the opening by Mr. Doran, senior
29 counsel for the Inquiry, mental health compulsory

1 treatment powers were governed by the Mental Health
2 Northern Ireland Order 1986, and that gave limited but
3 important powers for compulsory treatment for persons
4 suffering from a mental disorder where the statutory
5 test was met. Oversight of the powers of detention was 10:21
6 placed upon the then Mental Health Commission and
7 transferred to the RQIA in 2009. Detained patients
8 were entitled to apply to the Mental Health Review
9 Tribunal, or have an application made on their behalf
10 to be discharged as patients from compulsory treatment 10:22
11 if detention was not warranted, or if a tribunal was
12 not satisfied that discharge would create a substantial
13 likelihood of serious physical harm to themselves or
14 others. And there is a duty on the detaining authority
15 to refer cases to the Mental Health Tribunal annually 10:22
16 for children and biannually for adults under the Mental
17 Health Order.

18
19 The Attorney General in the Department of Health, and
20 the Master of Care and Protection of the High Court 10:22
21 also had power to refer a patient liable to detention
22 to the Review Tribunal. Patients had the right to be
23 represented at reviews by a legal representative.
24 However, many of our clients were not informed that
25 they could attend the tribunal, or that their loved one 10:22
26 had the right to legal representation before it. To
27 most of them this important, and some might say
28 fundamental check and balance on the exercise of such
29 power, was believed to be rubber stamping or just an

1 administrative exercise.

2
3 So if we now follow on from the Bamford Review and its
4 recommendation that there should be a single,
5 comprehensive, legislative framework for the reform of 10:23
6 mental health legislation and for the introduction of
7 capacity legislation in Northern Ireland, we come to
8 the Mental Capacity Act of Northern Ireland 2016 being
9 passed, and that fuses mental capacity and mental
10 health compulsory treatment powers, and there has been 10:23
11 a phased introduction of this legislation which means
12 that some patients are still detained under the Mental
13 Health Order, including the loved ones of some of our
14 clients.

15
16 If we move on though. In addition, the Human Rights
17 Act 1998, and the obligations imposed by the Northern
18 Ireland Act of 1998 on public bodies in relation to it,
19 forms an important context with which the mental health
20 legislation operates, and of particular significance is 10:24
21 Article 5, the right to liberty; Article 3, the
22 absolute prohibition on torture, inhuman or degrading
23 treatment; as well as Article 8, the right to respect
24 for private and family life and to the home. The
25 European Court of Human Rights has provided that in 10:24
26 respect of compulsory treatment powers, detention must
27 be in accordance with the law, and not arbitrary, and
28 must be free from bad faith or deception. The European
29 Court has repeatedly held that the deprivation of

1 liberty is such a serious measure that it is only
2 justified where other less severe measures have been
3 considered and found insufficient to safeguard the
4 patient or public, and that's the very thing that
5 should be being considered when they go before the
6 Mental Health Tribunal. 10:25

7
8 Just now to come to the professional standards and
9 values. Health professionals are regulated by strict
10 codes of conduct which require professionalism, a 10:25
11 person centred approach informed by the concepts of
12 dignity and compassion, and I am sure there are those
13 on the Panel who are only too well aware of those
14 professional standards and values.

15 10:25
16 Then our clients consider that the first standard is to
17 keep their loved ones safe whilst they're in Muckamore.
18 Many of them wanted to see the care plans and risk
19 assessments of their loved ones, which would have
20 informed them as to how that standard was going to be 10:25
21 achieved, but they were rarely allowed to do that.
22 They raised concerns over their loved ones' access to
23 appropriate medical investigation and care, as well as
24 the management of risks, such as the risk from choking,
25 but felt they were not listened to. The way to Go 10:26
26 Report refers to the choking risk, citing from one
27 example: He is a two year old in a man's body. He can
28 easily choke if he's not supervised and he's left with
29 food in front of him three times. And it notes two

1 inquests into the deaths of patients, one in November
2 2014 due to choking on food, and another in October
3 2017 who was at risk of aspiration and whose cause of
4 death was acute peritonitis due to perforation of the
5 small intestines resulting from a swallowed teaspoon. 10:26
6 He was on two-to-one observation.

7
8 Earlier this year the brother of one of our clients,
9 who was also at risk of choking when eating, and also
10 required two-to-one observation, nonetheless died of a 10:26
11 heart attack following a choking incident in Muckamore,
12 and there is an inquest to be held on that so I don't
13 want to say anymore about that.

14
15 Our clients also felt that it invariably fell to them 10:27
16 to insist on a referral to hospital for their loved
17 ones. So if one looks at their medical needs now.

18
19 The Inquiry will hear their evidence on issues such as
20 adverse reactions to medications, significant weight 10:27
21 loss, persistent chest infections, effects of
22 swallowing foreign objects, for which they had to seek
23 medical attention. And in many cases they felt they
24 were not taken sufficiently seriously, or not taken
25 sufficiently seriously early enough, and they were just 10:27
26 family members stepping in to the medical area to try
27 and get proper help for their loved ones.

28
29 For some of their loved ones this had disastrous

1 consequences. For example, one case of so-called
2 scabies turned out to be a known adverse reaction to
3 medication, a persistent chest infection was diagnosed
4 on admission to hospital - when the patient was finally
5 taken there - as double pneumonia. The swallowed 10:28
6 object that was not passed required surgery to remove
7 it. The way to Go Report noted the absence of physical
8 healthcare screening and lack of general medical
9 services that is unable to properly explain why, in
10 those circumstances, knowing that, that families were 10:28
11 not properly listened to, families who saw their loved
12 ones so regularly were not listened to when they were
13 trying to say "something's changed, there's been a
14 deterioration".

15
16 Our clients also consider that ensuring that their 10:29
17 loved ones' human rights were respected is a basic
18 standard to be met. They have continually raised
19 concerns about the use of the seclusion room. The way
20 to Go Report cites the Hospital data for 2015, 2016, 10:29
21 and 2017 for the use of the seclusion room. It does
22 that at paragraph 58 of the report. And notably in
23 2015, statistics show that one patient was subject to
24 seclusion on 78 occasions in a single month and
25 continued to be subjected to high levels of seclusion 10:29
26 in 2016 and 2017. Most of our clients identify a
27 failure to protect the dignity of their loved ones,
28 which is an issue of considerable importance to them.
29 And that is particularly in the case of personal

1 hygiene, that most sensitive of areas, which some of my
2 clients' loved ones cannot manage by themselves.

3
4 Many of them needed help to do something as basic as
5 just go to the toilet, and yet they were often ignored 10:30
6 when they wanted to, leaving them not only to wet or
7 soil themselves, but then to be left to wait helplessly
8 to be cleaned.

9
10 Our clients say that staff often did not make sure that 10:30
11 their loved ones were properly covered and were
12 careless as to whether they were exposed. The
13 narratives of our clients' experiences are replete with
14 references to a lack of compassion from the staff, and
15 as for dignity, the recent media report on the 10:30
16 experience of our client's son that was caught on CCTV,
17 speaks for itself. It's in the public domain. He had
18 been kicked in the groin, punched on the shoulder,
19 trailed across the ground with his genitals exposed.
20 whilst our clients do accept that the behaviour of 10:31
21 their loved ones could be challenging, many of them
22 know because they lived at home before they went into
23 Muckamore, they found the extent to which this was met
24 with rough handling, ridicule and humiliation
25 unjustifiable and extremely distressing. 10:31
26

27 Now, Mr. Aiken acknowledged in his opening for the
28 Trust that not only were professional standards
29 compromised in what happened at Muckamore, but the

1 values of the Trust were betrayed, and my clients would
2 agree with that.

3
4 So then what happened with all these expectations and
5 the law and the apparatus of professional standards, 10:31
6 what happened? Well, as will have been appreciated,
7 notwithstanding the background of that complex
8 government structure and arrangements that Mr. Doran
9 referred to in his opening for the Inquiry as being
10 comprehensive and appropriate, and the standards that 10:32
11 were expected, the situation in Muckamore was allowed
12 to develop to the point where the PSNI is conducting
13 what Mr. Robinson, in his opening, acknowledged is the
14 largest, adult safeguarding investigation in the United
15 Kingdom. So, with all of that apparatus, nonetheless 10:32
16 that's where we are.

17
18 Significantly, the abuse that we now know about did not
19 arise overnight with the installation of CCTV in July
20 2015, and leaving aside the evidence that our clients 10:32
21 will give to this Inquiry about the length of time over
22 which they have been querying the care and treatment
23 received by their loved ones, the issue of
24 ill-treatment or inappropriate treatment of patients
25 was known, albeit not necessarily being picked up by 10:33
26 the media always, it was known well before 2nd December
27 1999, which is the start of this Inquiry's
28 investigation period.

29

1 The Belfast Telegraph carried a piece in February 2007
2 called: "Sex abuse probe at Muckamore Abbey" - pretty
3 targeted - which reported that in 1992 a former patient
4 of Muckamore had launched a legal claim against the
5 Eastern Board claiming that he had suffered physical, 10:33
6 sexual and psychological abuse when he was a patient in
7 Muckamore more than 30 years prior. So at the very
8 least in 1992 somebody knew about that. His medical
9 notes and records disclose references to similar
10 incidents of a sexual nature between him and an older 10:33
11 male patient and to similar incidents involving other
12 patients - both adults and minors. As a result, the
13 Eastern Board and the Trust launched a review in 2005
14 to determine, on the information of similar activity
15 involving other patients in the 1970s and 80s, and the 10:34
16 results of that were presented to the PSNI, and the
17 Board and Trust launched a second fact finding review
18 of patient files in 2006, which is reported as having
19 involved up to eight files, which included reports of
20 sexualised behaviour between adults and minors, and up 10:34
21 to 33 files on non-consenting sexualised behaviour
22 between adults. The emphasis obviously being on
23 non-consenting.

24
25 The same Belfast Telegraph piece reported on a 10:34
26 statement by a police spokesman that confirmed that the
27 PSNI was investigating allegations of inappropriate
28 behaviour between patients in Muckamore occurring in a
29 period at the Hospital between the 1960s and the 1980s.

1 This is not new for Muckamore.

2
3 One of our patients who was at Muckamore in the 1970s
4 doing inservice training to become a social worker,
5 will give evidence that whilst he was working in his 10:35
6 assigned ward there was inappropriate sexual activity
7 between patients. He asserts that staff knew this was
8 going on and who would be involved typically. We have
9 many clients whose loved ones were in Muckamore at that
10 time, some of whom remain in Muckamore, and the Inquiry 10:35
11 will hear their evidence.

12
13 Inspections at Muckamore over that period, which is
14 where you might hope would discover some of that kind
15 of activity, that would have been carried out by the 10:35
16 Mental Health Commission, and as is made clear by
17 Mr. Neeson in his opening for the RQIA, our client's
18 hope that the Inquiry will consider those reports as
19 part of its investigation into who knew what and when
20 as a precursor to the issue as to how these things 10:36
21 happened and were allowed to happen.

22
23 Well, what might loosely be called the Bamford era of
24 investigation analysis was ushered in by the
25 commissioning in 2002 of an independent review of 10:36
26 mental health and learning disability by the Minister
27 for Health, and the Terms of Reference of which
28 required consultation with all relevant stakeholders.
29 The first report of that: "A Strategic Framework For

1 Adult Mental Health Services", was published in June
2 2005, and it includes a user reference group statement,
3 or as they termed themselves "the experts by
4 experience", and a statement prepared by the carers'
5 reference group, and together they were well placed to 10:37
6 ensure that there will be no shortage of access to
7 information on the conditions and practices of
8 Muckamore.

9
10 Furthermore, Marie Crossin, who had direct knowledge of 10:37
11 mental health services in Northern Ireland, and was
12 Chief Executive of Carers and Users Support Enterprise,
13 was a member of the steering committee. So you'd like
14 to think that they should have known what was happening
15 in Muckamore. 10:37

16
17 And there is then a report in 2012 by a care assistant
18 from Bohill Care Home, and she was working in
19 Muckamore, and she reports that she had witnessed
20 verbal and physical abuse of patients by staff, and the 10:37
21 details of that are set out in the Trust's report
22 "Ennis Ward Adult Safeguarding Investigation", or the
23 Ennis Report, and that was dated 23rd October 2013.
24 And that is the beginning of quite an important period
25 of investigation analysis of what was happening in 10:38
26 Muckamore.

27
28 An incident involving the sister of one of our clients
29 is referred to in that report. This patient, now sadly

1 deceased, had a significant learning disability and was
2 non-verbal, and the report records that the care
3 assistant alleged that a member of staff had ridiculed
4 our client's sister, encouraging her to fight back when
5 attacked by another patient and goading her, "go on, 10:38
6 hit her back you big softy", and the Ennis Report goes
7 on to record that she witnessed patients hitting out at
8 staff and each other with no intervention.

9
10 The Inquiry will consider, we believe, that Ennis 10:38
11 Report and its findings, and will be able to form its
12 own view. At this stage, we simply draw attention to
13 the fact that the evidence of our client, who was a
14 trainee in 2008 at Muckamore, is to a very similar
15 effect. His instructions are that there was loads of 10:39
16 violence between patients, and at times staff would
17 break up a fight between patients by deliberately
18 calling on another patient to intervene using force.

19
20 So, as I said, the Ennis Report in 2012 starts this 10:39
21 much more intensive phase of investigation of
22 Muckamore, and I refer to that as the 2012 to 2017
23 phase, and it's during that that it was investigated
24 repeatedly, and we start with the independent review
25 team commissioned by the Trust in 2017 to conduct a 10:39
26 Level 3 SAI into patient safeguarding practices at
27 Muckamore between 2012 and 2017, and the review team's
28 report: "A Review of Safeguarding at Muckamore Abbey
29 Hospital - A Way to Go", was provided in November 2018,

1 although only a summary was published in February 2019.

2
3 The "A Way to Go" Report, which I'm sure the Panel has
4 read, and many here have, is damning. Paragraph 55
5 states that:

10:40

6
7 "Between April 2012 and September 2017, the Hospital
8 recorded 128 allegations concerning staff working on
9 PICU, Six Mile, Killead, Ennis, Oldstone, Greenan,
10 Cranfield, Mallow, Donegore, Moylena and Erne."

10:40

11
12 Over 92 of these allegations concerned physical abuse,
13 and 102 (80%), concerned physical abuse combined with
14 institutional abuse, psychological abuse, verbal abuse
15 and psychological/emotional abuse. Thus, the most
16 typical type of allegation concerning staff is physical
17 abuse. That's typically what happened amongst a
18 catalogue of abuse. It is a grim catalogue of abuse.
19 Even so, it deals only with recorded allegations. And
20 our clients fear that not all allegations were
21 recorded. Many of them have loved ones on those wards
22 at that time and they complained of abuse. Still
23 others were on those wards at earlier times, outside
24 the scope of this Inquiry, and they also made
25 complaints, and they now know, from the way to Go
26 Report, that at least for PICU, the CCTV shows patients
27 being harmed by staff and yet no safeguarding referrals
28 were made. Yet no members of staff spoke out. And
29 that's what concerns them. No safeguarding referrals

10:41

10:41

10:41

1 being made. They hope to discover, through this
2 Inquiry, what happened to their loved ones and how the
3 complaints that they made were treated and why.
4

5 The final report seeking to address what happened is a 10:42
6 Review of Leadership and Governance at Muckamore Abbey
7 Hospital, and that's dated 31st July 2020. It was
8 commissioned in 2019 by the Department, the Health and
9 Social Care Board, and the Public Health Agency, as to
10 the effectiveness of trust leadership and governance 10:42
11 arrangements. They considered that particular element
12 merited further examination in the light of the way to
13 Go Report, and the review team explored the issue from
14 the perspective of three events. In this investigation
15 that I mentioned earlier, the installation of CCTV and 10:43
16 a complaint made by one of our clients about how an
17 assault on his son was handled, and so far as our
18 clients are concerned, a critical finding was that the
19 comprehensive governance arrangements were not a
20 substitute for staff at both MAH level and director 10:43
21 level in the Trust exercising judgment and discernment
22 about matters requiring escalation.
23

24 Furthermore, leadership was also found wanting at
25 director level as issues relating to the staffing 10:43
26 crisis at MAH and its impact on safe and compassionate
27 care was not escalated to the executive team or Trust
28 Board as a means of finding solutions. The Inquiry
29 will form its own view of course, but it is the hope of

1 our clients that the investigation will critically
2 examine the role of those in charge who have the
3 ability to address staff shortages and who should have
4 made it their business to ensure that there was
5 adequate oversight and accountability in what was going 10:44
6 on. So not just what individual care workers or nurses
7 did in the ward, but those in charge, our clients are
8 particularly anxious that they should be looked at as
9 well because they had that ability to ensure
10 accountability and oversight. 10:44

11
12 Mr. Chairman, I wonder if that might be a convenient
13 place just to break now?

14 CHAIRMAN: Yes. Certainly. If we were to take a
15 quarter of an hour now, do you think you'll finish the 10:44
16 second part of your address in the second session, as
17 it were?

18 MS. ANYADI KE-DANES: I very much hope so. That's my
19 intention.

20 CHAIRMAN: All right. Well thank you very much indeed. 10:45
21 Can I remind everybody about masks when they move
22 around.

23 MS. ANYADI KE-DANES: Thank you.

24
25
26 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

27
28 CHAIRMAN: Thank you. I was asked for a short delay,
29 and I gather things have resolved themselves?

1 MR. DORAN: Yes, Chair.

2 CHAIRMAN: Yes. Thank you. Could I also -- I have
3 been asked to remind everybody, particularly those
4 sitting in the public gallery, of the importance at the
5 moment, I'm afraid, of wearing masks. As we all know, 11:07
6 there is a current new virulent strain, hospital
7 admissions are going up, and we have a particular
8 responsibility because you may be sitting next to
9 somebody who has caring duties at home and those people
10 may be particularly sensitive. So, could I -- I'm 11:07
11 sorry to interrupt you, Ms. Anyadike-Danes -- but could
12 I just remind everybody, please, moving around, please
13 do wear masks and remember about testing twice a week,
14 if you would. All right. Thank you very much.

15 MS. ANYADIKE-DANES: Thank you, sir. 11:07
16

17 That short break that you gave - or the short extension
18 I think to the break, I'm very grateful for. There was
19 an issue to be resolved and it's a correction I need to
20 make, and if you've got a correction to make it's best 11:07
21 to make it as soon as possible, so I'm doing that now.

22 CHAIRMAN: Yes. Quite.

23 MS. ANYADIKE-DANES: I had referred to Mr. Doran, who
24 obviously is senior counsel for the Inquiry, as having
25 effectively endorsed the complex governance and 11:08
26 structural arrangements by saying they were
27 comprehensive and appropriate. That wasn't Mr. Doran's
28 language, that was the language of the Review and
29 Leadership in Governance of Muckamore Abbey Hospital

1 Report of 2020. That was their language. Mr. Doran
2 referred to that report, but he wasn't himself claiming
3 that that is something that should be attributable to
4 the structure. So I thought I'd correct that
5 immediately.

11:08

6 CHAIRMAN: Indeed. Thank you.

7 MR. DORAN: Chair, I'm grateful to my Learned Friend
8 for that correction.

9 CHAIRMAN: Yes. Thank you very much indeed.

10 MS. ANYADI KE-DANES: So, so far, what I was -- what I
11 have been dealing with is the betrayal element, not
12 only the framework that gave rise to expectations, the
13 expectations that were had and then what happened. I
14 now want to move on to a section that I've called "the
15 silenced".

11:08

11:08

16
17 The current Chief Executive of the Trust, Dr. Cathy
18 Jack, made a video statement on 5th August 2020, after
19 the publication of that very report I've just referred
20 to, the Leadership and Governance Review, and it is
21 cited in detail by Mr. Aiken in his opening for the
22 Trust, but it includes these words:

11:09

23
24 "The CCTV has given a voice to our patients and tells
25 their story that they could not tell themselves."

11:09

26
27 well, I want to say a little bit about the voices that
28 my clients did have. Because in fact they did use the
29 voices they had. Our clients' loved ones are a mixture

1 of the non-verbal and those with varying levels of
2 speech, but it's not correct to characterise - and I'm
3 not saying that she did that, but lest it be thought -
4 it's not correct to characterise them as without any
5 means of expression. It was certainly a mistake of 11:10
6 their carers to assume - if that's what they did - that
7 they would be unable to find a means of communicating
8 their pain, distress, sadness and fear, because they
9 did, and they were doing so to their families, long
10 before the existence of CCTV footage that came to light 11:10
11 in August 2017.

12
13 Some, who were not speech impaired, did speak out.
14 Some of our clients will give evidence. One of them,
15 that her son, who had severe learning difficulties with 11:10
16 autistic symptoms, told her he was being abused in his
17 bedroom, in the shower, in Killead ward, and a member
18 of staff had forced him to the floor whilst another had
19 kicked his buttocks. On another occasion a male care
20 worker who was helping to support him during his 11:11
21 showering and toileting caught him in the genital area
22 and put him to the floor.

23
24 Another client will say that her daughter, who has a
25 neurological condition and a learning disability, told 11:11
26 her a man threw her to the floor and put her in jail,
27 and that she thought he was going to rape her.

28
29 Now, her reference to "jail" turned out to be the

1 seclusion room, which our client insisted on being
2 shown. whilst the reference to "rape" was something
3 that she had knowledge of as she had been sexually
4 assaulted in the community shortly before her admission
5 to Muckamore. 11:11

6
7 Some of our clients' loved ones who had great
8 difficulty with speech, nonetheless found some words.
9 A client's sister who had an acquired brain injury and
10 little speech still managed to say "hit" with reference 11:12
11 to a "man", and referred to "girl push" and "lock
12 door". Now she has since passed away in Muckamore,
13 some 20 years after her admission.

14
15 Yet another of our clients will say that her aunt, 11:12
16 diagnosed with epilepsy and brain malfunction, and
17 largely non-verbal, was nonetheless say "hurt me".
18 She, too, has passed away having been at Muckamore for
19 about 50 years.

20 11:12
21 Others communicated through a form of role play. One
22 client recalls an incident in 2007 when her son had
23 extensive bruising from hip to knee and she will give
24 evidence that when he was asked about it he
25 demonstrated on her partner being thrown up hard 11:12
26 against a door frame and saying "get in".

27
28 Our clients believe that for a variety of reasons some
29 of their loved ones manifested the abuse that they had

1 suffered and the impact on them in self-injurious ways.
2 Some of them stopped eating, or ate less than they had
3 previously. Others engaged in head banging and other
4 forms of self-harm. Some took to the dangerous
5 practice of swallowing foreign objects, such as 11:13
6 batteries and broken parts of CDs. Our clients
7 understand that in some cases they did this as a rather
8 desperate means of getting out of Muckamore, albeit it
9 would only get them to another hospital.

10
11 There were also those who by their very demeanour
12 signalled to their families that something was wrong.
13 Appearing afraid. Shying away from some member of
14 staff. Clinging on to the doors to stop being returned
15 after a visit. Or losing interest in everything, 11:13
16 withdrawing and seeming profoundly sad. Very difficult
17 to envisage the impact that has on a loved one when you
18 leave your loved one in a place like that and they are
19 desperately clinging on to a door to stop you going or
20 to stop being left. 11:14

21
22 So what was the significance of the CCTV? well, our
23 clients don't wish to minimise that it had a
24 significance, because it did. Having access to the
25 CCTV footage clearly was significant. They know that 11:14
26 there was abuse to their loved ones that they did not
27 pick up and which they were absolutely shocked to learn
28 about for the first time when they got a phone call
29 from the PSNI or the Trust. The CCTV has also had the

1 effect of validating our clients' accounts, and those
2 of their loved ones, that abuse was happening, and
3 making it harder to dismiss any accounts of such abuse
4 in the future as simply lacking credibility.

5
6 The importance of that cannot be overstated because it
7 now seems to them that the real issue was not whether
8 our clients' loved ones could give voice to the abuse
9 they suffered, but whether that communication would be
10 regarded as credible and whether their relatives and
11 friends who raised concerns on their behalf would be
12 believed.

13
14 We know, for example, that many claims of abuse were
15 prematurely dismissed by staff in Muckamore due to
16 alleged concerns about the credibility of those claims.
17 Many of our clients noticed bruising on their loved
18 ones' bodies, or even broken toes, and when asked for
19 an explanation they were routinely told it was
20 clumsiness or self-harm. Such an explanation - and
21 this was the real difficulty with it - such an
22 explanation was inherently plausible, because some of
23 them simply could not comprehend that their vulnerable
24 loved ones would be harmed in a hospital where they had
25 been taken to for help. So if they were told, 'well
26 that bruise happened because they dropped down, had a
27 seizure or they but bumped into something', they were
28 predisposed almost to believe that. Who could conceive
29 that that was intentionally inflicted or allowed to be

1 inflicted?

2

3 But there were others who simply refused to accept that
4 kind of explanation. It just didn't fit with their
5 knowledge of their loved one at home, or the 11:16
6 circumstances of the injury of what their loved one was
7 communicating. And when they did that, when they
8 challenged it, they faced opposition on two fronts; to
9 the very suggestion that anything untoward could
10 possibly have happened, and then a very long battle to 11:16
11 discover the truth.

12

13 So, the first was from the carers themselves, some of
14 whom the CCTV showed perpetrating abuse while others
15 saw it happen. And the other opposition? That was 11:17
16 from management who simply accepted their staff's
17 account.

18

19 That response is noted in the way to Go Report which
20 found that even the possibility of patients being 11:17
21 harmed was denied and deemed implausible by hospital
22 managers and the RQIA and, also, over a third of
23 safeguarding files state that patients have a history
24 of making allegations which sacrifices patient's
25 credibility. They simply dismiss it 'oh, they always 11:17
26 do that'. You'd miss the one that they're trying to
27 tell you about that has really happened.

28

29 Our clients also found that not only was a suggestion

1 of abuse denied, but that their loved ones were
2 intimidated to prevent them even reporting it, even
3 communicating to the vary ones their families, who they
4 would otherwise trust to help them, intimidated out of
5 doing that, discussing it with them, and there was a 11:18
6 pervading sense of fear.

7
8 One client will say that her son disclosed the names of
9 people who were, as he put it, "bad to him", but she
10 said -- and when she said she would go and sort it out, 11:18
11 he would then go back on what he said and was afraid of
12 what might happen.

13
14 Another client will say that her son had significant
15 bruising but clammed up when she asked him what had 11:18
16 happened, and she took photographs of those bruises on
17 her phone, but was told by staff that she'd have to
18 delete them if she wanted to see her son again. And
19 they threatened to take away her phone and tried to
20 force her to sign a form about the photographs, which 11:18
21 she refused to do. And she learnt from her son that he
22 had been told by a member of staff that if he talked
23 about abuse they would cut off his penis and break his
24 jaw.

25 11:19
26 Her evidence will be that her son became so scared of
27 telling her about abuse, and she, for her part, was so
28 fearful of making any case report in case he suffered
29 as a result of her. He's now out of Muckamore and she

1 says - and will give evidence - he can rhyme off those
2 names of those who abused him and he knows exactly who
3 did what and what they did.
4

5 Yet another client will say that her brother was very 11:19
6 afraid of being overheard telling her about hurt and
7 ill-treatment. That he didn't want her to have fair
8 cause transferred to the visitor's room which would
9 have give them more privacy. The reason he didn't want
10 that is that even if she were to request that, that 11:20
11 might be suggestive, and he would be told off for
12 being, as he put it, "a bad boy".
13

14 She will also say that the family did complain about
15 his treatment and were told that he would be moved to a 11:20
16 facility in Birmingham as he was too violent to
17 continue in Muckamore. Well that didn't happen, and
18 subsequently the family was informed by PSNI that
19 following the current review of CCTV, their loved one
20 was captured being abused in 166 separate incidents. 11:20
21

22 When the family spoke to him about it afterwards, he
23 was distressed and he indicated that he didn't mention
24 it because he was frightened. The evidence that they
25 will give will be that he was told, and threatened 11:20
26 with, that if he complained he would be moved away from
27 Northern Ireland, away from them, to a facility in
28 England.
29

1 So in addition to validating the accounts of the abuse
2 of their loved ones, our clients recognise the
3 considerable advantage of having the CCTV footage to
4 show what was happening on certain wards, without the
5 staff appreciating what was being recorded. It has 11:21
6 indicated, not only the industrial scale with which
7 abuse was happening, but also the way it happened, the
8 apparent indifference to the effects of raised voices,
9 physical violence, punishment, isolation, and the
10 ignoring of cries and pleas for attention or 11:21
11 assistance. The casual ignoring of the effect of that
12 on people who have mental health issues and learning
13 disabilities. That would be bad enough for people who
14 don't, let alone people who have been taken to a
15 facility to help them with those issues, to then be 11:22
16 faced with that. Those on the Panel who have medical
17 experience will appreciate how some of that could
18 affect people suffering from autism and so on and so
19 forth. They consider it demonstrates not just the need
20 for change to the whole culture in Muckamore that 11:22
21 allowed such abuse to be carried out, seemingly with
22 impunity, but also the sheer extent of the system's
23 failure that was unable to detect what was happening at
24 the senior levels and address it.

25
26 So, just to finish off that section to say they have
27 been heard. Our clients consider that the evidence of
28 the abuse to their loved ones was clear, and in many
29 cases was known about by the Trust, or should have

1 been, before August 2017, this current review of CCTV,
2 when apparently the Trust first appreciated that CCTV
3 was already live and footage available. They believed
4 that their loved ones were not silent, rather they were
5 silenced by a system that would not see, or if it did 11:23
6 see, would not properly respond.

7
8 So, now I wanted to say something about a culture of
9 impunity. How does that happen? It's hard to conceive
10 of a greater betrayal than the sustained abuse of 11:23
11 vulnerable patients by those who are charged to care
12 for them. Most of these patients could not articulate
13 what was happening in precise terms and had to find
14 other ways to express their suffering, distress and
15 despair, or presumably trust their relatives and carers 11:24
16 would find a way to do it for them. All of them were
17 isolated and effectively at the mercy of their abusers.
18 And when I say "isolated", I don't mean that their
19 families didn't visit them, but they were physically
20 isolated. For them and their families this begs the 11:24
21 ultimate question: why? why did this happen in a
22 place which has been set and has its raison d'être to
23 care for them?

24
25 This Inquiry will quite properly spend much of its time 11:24
26 considering the evidence to try and understand how such
27 abuse could occur in a modern health system, but
28 eventually this must give way to the harder question of
29 why the names of some of our hospitals have now become

1 synonyms for abuse. Ely Hospital, Winterbourne View,
2 Whorlton Hall, and now Muckamore Abbey has joined that
3 inglorious list.

4
5 while this is for the Inquiry to answer, we 11:25
6 respectfully suggest that this harder question calls
7 for examination of the culture of impunity that
8 operated in Muckamore and more widely over many years.
9 By this we mean a culture where actions do not have the
10 usual consequences, where obvious wrongdoing no longer 11:25
11 seems quite so wrong, and where no one is held
12 accountable for it, or at least not enough of them who
13 are doing it. All of which seems to be a pre-requisite
14 for the abuse of power and patients. Such a culture of
15 impunity, we suggest, requires at least three key 11:26
16 components.

17
18 1. A veneer of governance.

19
20 2. The place of the abuse is a closed world, a place 11:26
21 apart.

22
23 3. Complicity of a dysfunctional management system.

24
25 So let's look at the veneer of governance, the first 11:26
26 component. We find that the Leadership and Governance
27 Review concluded that both the Trust and Muckamore had
28 in place the necessary governance arrangements. In
29 particular, it states at paragraph 6.30 that:

1
2 "Governance structures were in place at Board and Trust
3 level to enable the Trust to assure itself of the
4 quality of the services it provided at MAH."

5 11:26

6 In addition, the Trust also had a number of systems in
7 place to record and monitor adverse incidents, serious
8 adverse incidents, and complaints, as part of its risk
9 management strategy.

10 11:27

11 Muckamore was also monitored by the RQIA, which, over
12 the course of its inspections, collated significant
13 information on practices within wards and acquired
14 verbal feedback from patients and staff. That said, of
15 course, the RQIA did not actually serve improvement
16 notices on the Trust in respect of Muckamore until
17 November 2019, because of when it took over operations,
18 and by then too little too late we would say.

19 11:27

20 whilst Muckamore was ostensibly awash with information
21 and data pertaining to vulnerable adults, physical
22 interventions, restraint and seclusion, the 2020 review
23 found that there was no evidence of meaningful analysis
24 of this data or any appreciation of emerging trends -
25 at least not publicly. This, according to the 2020
26 Review, directly contributed to the overuse and misuse
27 of physical intervention, restraint and seclusion. For
28 a culture of impunity to flourish requires this veneer
29 of governance and regulation to hide or distort the

11:28

1 reality of what is actually going on.

2
3 Form quickly takes precedence over substance in such a
4 culture. For example, the Trust's Discharge of
5 Statutory Functions Report from 2012 to 2017 were 11:28
6 largely repetitive and gave little sense of the actual
7 compliance with statutory functions, and this is also
8 well illustrated by the Trust's approach to the
9 allegations of abuse in Ennis Ward in November '12,
10 which resulted in the Ennis Report that I've referred 11:29
11 to earlier.

12
13 Notwithstanding the recommendations made, it should be
14 noted that even this investigation sought to
15 inappropriately minimise the seriousness, we would say, 11:29
16 of the allegations. The Trust found that while it was
17 thought unlikely that Bohill staff would falsely report
18 such abuse, it still had to be acknowledged that they
19 were working in a new environment where context of some
20 actions may not have been clear to them, it also 11:29
21 acknowledged that some staff from Bohill were coming
22 from a newly built, bright spacious physical
23 environment, in contrast to an older style hospital
24 ward. Well it's not clear to my clients how a new
25 environment, or even the style of a hospital, could 11:29
26 ever be said to somehow contextualise otherwise serious
27 allegations of abuse. Indeed, some of these
28 allegations are resulting in criminal prosecutions.
29

1 But what this demonstrates, we say, is that although
2 the appropriate procedures may well have been in place,
3 they were not used or were not used effectively. They
4 represented, as we put it, a veneer of governance.

5
6 The Trust's response to the Ennis ward allegations was
7 subsequently criticised in the 2020 Review, Leadership
8 and Governance Review, as a missed opportunity to
9 address what they considered was institutional abuse as
10 the matter was not escalated. The 2020 Review
11 considered that this should have been addressed at the
12 time as an SAI and a formal complaint, and that review
13 concluded the problem was not in governance processes,
14 but rather in people's response to working in a closed
15 environment with its own norms and values and with
16 loyalty to the group rather than the patients or their
17 employing Trust.

18
19 So, what about the second component, a place apart? We
20 say this is also necessary for this culture of impunity
21 to develop. That closed environment. The 2020 Review
22 concluded that Muckamore was a self-contained community
23 with its own culture and identity being viewed by the
24 Trust as a place apart. This cultural autonomy was,
25 however, toxic to the point of being almost incestuous.
26 The Way to Go Report highlighted that some staff were
27 related, including from some families who had worked
28 there for generations, constraining the possibility of
29 true peer challenge. This review belatedly recorded

1 that there's an awful lot of nepotism in Muckamore.
2 It's not healthy. On the culture itself, way to go
3 found there was indeed a culture, a tolerated set of
4 norms or work practices which were harmful and
5 disproportionate. It was shaped by the use of power 11:32
6 relationships in which the words were closed,
7 visitors/relatives, as well as professionals, were
8 advised whether or not they could visit due to
9 unsettled patients, individual staff members were
10 comfortable working with certain staff, and cut and 11:32
11 paste records concerning the use of seclusion, for
12 example, were not challenged. So you could cut and
13 paste those records for the use of seclusion and it
14 doesn't seem that there was adequate challenge to that
15 practice. 11:32

16
17 The most obvious manifestation of how being a place
18 apart led to this culture of impunity relates to the
19 installation of CCTV cameras in Muckamore. These, we
20 understand, were installed from April 2015, and the 11:32
21 evidence suggests that they were recording since July
22 2015. At least that's what is reported in the review.
23 However, such was the sense of impunity by them
24 operating that even the presence of CCTV, whether
25 operational or not, just the infrastructure for it and 11:33
26 the cameras, did not seem to cause much, if any,
27 concern to those engaged in the systematic abuse of
28 patients. The presence of cameras was simply
29 insufficient to displace that dominant sense of being a

1 place apart. And even when the abuse was exposed via
2 CCTV recordings, this was initially denied or claimed
3 to be "implausible".
4

5 We would also observe in passing that damning as the 11:33
6 Way to Go Report is, that review team watched 20
7 minutes of what the PSNI now say is 300,000 hours of
8 CCTV footage, taken from select wards over only a
9 sixth-month period in 2017.

10
11 Arguably, the most invidious aspect of this sense that 11:33
12 Muckamore was closed off from the rest of the world is
13 a fact that for many patients this actually was
14 literally true. The Way to Go Report found that
15 Muckamore was plagued by mental health delayed 11:34
16 discharges. They were there, unable to get out
17 basically. Patients, whether admitted voluntarily or
18 detained, were often unable to return to their family
19 or into the community, even when they were ready for
20 discharge. 11:34

21
22 One of our clients will give evidence to the Inquiry
23 regarding his son's experiences in Muckamore. This
24 patient was detained in Muckamore from May 2017 for
25 assessment and treatment. His parents were advised 11:34
26 that this process would take between four to six weeks.
27 At a subsequent best interest's meeting in June 2017 -
28 so we are now considerably on from May 2017 - a
29 consultant psychiatrist noted that the patient would

1 benefit from a short admission and they would plan for
2 discharge later that summer. He did not leave
3 Muckamore until February 2020.

4
5 Another client was told by the Trust in the summer of 11:35
6 2018 that her brother would be resettled into the
7 community and there was a property identified and
8 earmarked for him. He was assessed as medically fit
9 for discharge in June 2019, but died earlier this year,
10 still in Muckamore, and before the judicial review 11:35
11 proceedings his sister was bringing to compel his
12 resettlement could be issued.

13
14 For some patients this meant being kept in Muckamore
15 for much longer than was necessary, with significant 11:35
16 adverse consequences for their health and wellbeing.

17
18 One patient had long engaged in serious self-injurious
19 behaviours in Muckamore, but these stopped when he was
20 moved to a setting within the community, and the 11:36
21 concern that families have is that these patients,
22 their relatives, loved ones, could be moved earlier and
23 that they have unnecessarily suffered from being
24 required to stay in Muckamore.

25 11:36
26 Our patients hope that the Inquiry will identify the
27 constraints on discharge, the causes of delay, and how,
28 in practice, that can be addressed in the interest not
29 just of their loved ones who remain in Muckamore

1 despite being deemed medically fit for discharge, but
2 others who also want to get out.

3
4 Then the final of the three parts: complicity of a
5 dysfunctional management. 11:37

6
7 Those clients/Core Participants that we represent have
8 frequently stressed to us that whilst they want those
9 who abused their loved ones brought to justice, this is
10 not enough. Those who abused were subject to 11:37
11 management and it is this management that created
12 and/or failed to prevent the development of this toxic
13 culture of impunity. In this sense at least management
14 were complicit in the abuse that occurred. Those in
15 charge, those who might have intervened to stop this 11:37
16 disgrace, in my clients' view must also be held
17 accountable. Even when Trust processes were utilised
18 they were ineffective - and that's another thing that
19 need to be considered.

20 11:37
21 Following the Ennis Report, the Trust repeatedly
22 advised the Board that the safeguarding investigation
23 was unable to substantiate the allegations even though
24 the PPS had determined that charges should be brought,
25 applying the test for prosecution which necessarily 11:38
26 meant that they had judged there to be a reasonable
27 prospect of conviction on the evidence.

28
29 More disturbingly still, an internal Trust e-mail dated

1 24th January 2013, which had been copied to the
2 designated officer leading the safeguarding
3 investigation stated that:

4
5 "There is a concern of possible institutional abuse and 11:38
6 a full understanding in terms of culture and past
7 history on Ennis is relevant."

8
9 Despite this, the Trust opposed an SAI in respect of
10 the Ennis allegations. It can be noted that the Ennis 11:38
11 Report was published in October 2013.

12
13 The 2020 review found that the leadership team at
14 Muckamore was "dysfunctional with obvious tensions
15 between senior members". Leadership was not visible. 11:39
16 Staff felt a sense of loyalty to each other and not the
17 Trust.

18
19 Following viewing of the CCTV footage from PICU, showed
20 an assault on one patient and ill-treatment of another, 11:39
21 the clinical director briefed the Trust's medical
22 director in September 2015, and the medical director's
23 notes of this meeting concluded the whole staff team -
24 meaning presumably at PICU - was complicit. That's an
25 extraordinary communication. 11:39
26

27 Even after 2017, when CCTV had emerged, there was
28 suppression of information within Muckamore. We know
29 this because one of the Core Participants, our client

1 that we represent, attended a meeting with a senior
2 official from the Department of Health during which
3 this official advised that there had been a period when
4 information was being contained in Muckamore. Now the
5 Inquiry will hear its own evidence and form its own 11:40
6 views. That is the concern that my clients have.

7
8 So, given these factors, it's now unsurprising, we say,
9 that a culture of impunity operated within and around
10 Muckamore. Abuse in this context was almost 11:40
11 inevitable, at least some of it, almost inevitable in
12 those circumstances, and those responsible for this
13 situation will now, our clients' trust, have to answer
14 to this Inquiry.

15 11:40
16 So, now I want to deal with the final part of this
17 opening on behalf my clients, and it's called the
18 response.

19
20 We want, now, to turn the focus to our clients and 11:40
21 their response to this awful scandal. Although many
22 must have been tempted to despair in the face of what
23 was being revealed, they did not fail their loved ones
24 or falter in their quest for answers. A quest that led
25 ultimately to this Inquiry. However, before looking at 11:41
26 how they achieve this, it is important to highlight a
27 perhaps more predictable but no less compelling
28 response from our clients.
29

1 Throughout all of this, our clients have sought to
2 provide consistent love, care and practical support for
3 their loved ones in Muckamore. A couple of examples
4 will illustrate this point.

11:41

5
6 One client, whose son spent years in Muckamore, would
7 speak to him on the phone twice a day, come what may.
8 Taking him home as often as she could, she consistently
9 challenged staff in the face of unexplained bruises
10 found on her son, pressed for dental treatment when her
11 son's pain had not been addressed, did all his washing
12 all the time he was in Muckamore, and finally took him
13 home in the face of the risk that she would be unable
14 to see him due to the Covid-19 pandemic. The impact on
15 the family of that has been significant, with her
16 partner having to take unpaid leave and eventually
17 resigning his employment to help and support their son
18 at home. That's a very significant commitment. All
19 the while you're campaigning.

11:42

11:42

11:42

20
21 In another case, a family of a patient looked after him
22 at home until he was 21 - he's the youngest of eight -
23 and whilst at home and before his admission, the family
24 looked after him and provided him with proper family
25 life willingly and lovingly. They revolved their lives
26 around him. This continued when he was admitted to
27 Muckamore in 1988. His mother feared that without
28 regular visits, due to his memory issues he would
29 become isolated and would forget his family. His

11:43

1 siblings, the eldest of whom is a client, responded,
2 and they made a rota to make sure that he had visitors
3 daily and experienced the love of his family. This has
4 continued for the last 34 years. And they are now
5 using all means possible, including litigation, to
6 secure his discharge so that they can bring him home.

11:43

7 CHAIRMAN: I'm so sorry to interrupt you, but I just
8 notice that on the Inquiry's screens - and this will be
9 happening in the Hearing Room B as well - we are seeing
10 images of what I assume are your clients.

11:43

11
12 You'll remember that I made a general restriction order
13 in relation to anonymity. Of course if they wish to do
14 that, they can waive that anonymity, and can I assume -
15 I just need it on the record - that in relation to all
16 those whose images that we are going to be seeing, they
17 have waived the anonymity in relation to the general
18 restriction order?

11:44

19 MS. ANYADI KE-DANES: Yes, you can. You can, Chair.

20 CHAIRMAN: Sorry to interrupt you. Thank you very
21 much.

11:44

22 MS. ANYADI KE-DANES: You can.

23
24 So, that loving care, that keeping him insofar as you
25 can, a person who is not physically with you, in your
26 family and making him know that he is part of your
27 family, that is a dedication willingly embarked on that
28 has continued for 34 years, and will continue, they
29 tell me, until they bring him home.

11:44

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In addition to such daily acts of love and devotion, our clients had the courage and the conviction to step up and speak out for their loved ones in the face of this insidious scandal. Their response was threefold: Organising campaign, continue their own oversight for those still in Muckamore, and press for resettlement.

11:45

I think it is important to remember these are ordinary people. Ordinary people, ordinary backgrounds, some of them still working. The campaign that followed demonstrates that one should never doubt a small group of thoughtful, committed people who want change. We've seen it in operation before. Recent examples are Hillsborough and Grenfell, but that should not understate the courage, the sheer courage and determination, and usually powering it all, love and concern, that such an endeavour takes.

11:45

11:45

Using the long-established network provided by The Society of Parent and Friends of Muckamore, our clients started to build their case. Some families, as noted, formed the group Action for Muckamore to highlight the issue for abuse. Together these groups sought information through Freedom of Information, subject access requests, anything they could find to start to build their case. They began to engage with that the media to tell their stories to as many people as they could. They met with officials. They consulted

11:46

11:46

1 experts. They eventually gained some traction to the
2 point that a compelling case for this Inquiry was made.
3 After the Minister had agreed to call this Inquiry, our
4 clients continued their campaign through the
5 consultation process with the Patient and Client 11:46
6 Council, filing numerous written submissions. There
7 would be no Inquiry but for these brave families. To
8 have secured this Inquiry whilst also providing the
9 continuing oversight and care for their loved ones was
10 a monumental achievement, and our clients fought to 11:47
11 ensure, in the face of historic incidents and ongoing
12 concerns, that they were there to guard the guards.

13
14 This is not a role that they should ever have had to
15 contemplate, let alone perform. Yet given the total 11:47
16 loss of trust that is what they felt was necessary.
17 For some clients this role continues as their loved
18 ones remain in Muckamore, where there is a present
19 feeling that staffing levels continue to be below what
20 is required. 11:47

21
22 Finally, there has been the long and ongoing campaign
23 for resettlement of patients in the community. Our
24 clients have engaged directly with the Trust and Health
25 and Social Care Board in trying to get their loved ones 11:48
26 out of Muckamore. They have instigated legal
27 challenges to secure appropriate care and unfortunately
28 such challenges continue to be necessary. Our clients
29 fear that their loved ones who remain in Muckamore

1 continue to be at risk of abuse, irrespective of the
2 legal issues. The human tragedy of this is that many
3 patients, upon release, have been able to live their
4 best lives in the community, integrated back into
5 ordinary family life, and the denial of this chance to 11:48
6 those who still remain in Muckamore is what spurs our
7 clients on. They want that too for their loved one.

8
9 The prospects of resettlement for some long-term
10 patients remains highly unsatisfactory, with some 11:48
11 patients and their loved ones having been informed that
12 resettlement could take another three years. This is
13 set against a policy expectation from as far back as
14 the 1970s that no one should live in a hospital.

15 11:49
16 One of our clients has a loved one who has been a
17 patient in Muckamore for 34 years, and deemed fit for
18 discharge for the last 25 years!

19
20 In a Way to Go Report this policy intention was 11:49
21 reiterated, and the Department acknowledged this in its
22 opening. Patients who are medically fit for discharge
23 are being forced to live in an environment where they
24 were abused, or at least some of them were abused, with
25 the concern that the environment itself is triggering 11:49
26 and harmful and may compromise the chances of
27 successful resettlement. So although on the one hand
28 their families are desperate to get them out so they
29 have their best chance, the longer they stay there the

1 more they fear that that is being compromised.

2
3 This concern is also reflected in the Way to Go Report
4 which states:

5
6 "While the reasons behind the delayed discharges are
7 multi-factorial, patients subjected to protracted
8 waiting for non-acute hospital provision are likely to
9 deteriorate."

10
11 And that's their worry.

12
13 This Inquiry is not, of course, required to establish
14 that it's wrong to abuse vulnerable patients in a
15 hospital setting, and I'd like to think everybody would
16 accept that. Nor is it required to establish that
17 people should not have to live their lives out in a
18 hospital. Indeed we already know from the Terms of
19 Reference what the Inquiry intends to investigate and
20 be making recommendations on. Not the detail of those
21 recommendations, but the issues. However, these
22 recommendations, important as they are, will
23 effectively be rendered of little assistance in
24 achieving the required change without the necessary
25 funding. Many have advised, for years, what's
26 required. They know what good practice looks like, but
27 we haven't got it yet, and there's a reason - my
28 clients think. That ultimately would be the test of
29 whether the State really does wish to end the

1 institutional abuse of patients, and this is not a new
2 issue either. More than ten years ago the Northern
3 Ireland Audit Office published a report on the
4 resettlement of long-stay patients from learning
5 disability hospitals, and it noted:

11:51

6
7 "Boards and Trusts told us that delays in resettling
8 patients arise primarily because of a lack of
9 sufficient resourcing for alternative forms of
10 provision. Within Northern Ireland, expenditure on 11:51
11 learning disability services per head of population has
12 been significantly lower than elsewhere in the United
13 Kingdom and, as a result, progress in resettling
14 patients has been much slower. However, the
15 Department's view is that relative expenditure on 11:52
16 learning disability services in Northern Ireland is
17 reflective of the 600 million underfunding of health
18 and social care services when compared with England.
19 We acknowledge that the Department faces real
20 difficulties in meeting current demand for 11:52
21 resettlement."

22
23 And here's the kicker:

24
25 "However, if the latest target for full resettlement is 11:52
26 to be met, learning disability must be given a higher
27 funding priority."

28
29 So, just in conclusion, Mr. Chairman, Panel, the moral

1 test of government is how that government deals/treats
2 those who are in the dawn of life - children, those who
3 are in the twilight of life - the elderly, those who
4 are in the shadows of life - the sick, the needy and
5 the handicapped. Our clients's faithfulness, courage 11:53
6 and persistence has not allowed their loved ones, or
7 the abuse they suffered, to remain in the shadows. The
8 public inquiry into what happened, how it happened and
9 what should be done in the future, for which so many of
10 them have fought, is now here, and with it best 11:53
11 opportunity to examine, when all the evidence is in and
12 the arguments made, how our public bodies stand in
13 relation to that moral test of government.

14
15 Thank you very much, Chair. Panel. 11:53

16 CHAIRMAN: Ms. Anyadike-Danes, thank you very much
17 indeed for that address. Can you make sure that
18 Inquiry counsel has access to these slides so that they
19 can form part of the Inquiry record.

20 MS. ANYADIKE-DANES: Indeed. I think they have been 11:54
21 e-mailed.

22 CHAIRMAN: Have they already been provided?

23 MS. ANYADIKE-DANES: We have e-mailed to the Inquiry
24 Office, not just the slides, but the opening with all
25 its references, and also the chronology that goes with 11:54
26 it from 1949 to today.

27 CHAIRMAN: Right. That's very helpful. Thank you very
28 much, indeed.

29 MS. ANYADIKE-DANES: Thank you, Chairman.

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END OF SUBMISSION BY MS. ANYADI KE-DANES

CHAIRMAN: All right. We're going to rise now and we will not be sitting publicly for the rest of this week. 11:54
As we've indicated, there'll be closed session hearings for the Panel to view CCTV footage.

Next week we are not sitting, and then of course we are hoping to start the evidence on the Tuesday thereafter, 11:54
as Mr. Doran has indicated.

So, could I thank everybody for their attendance today. I wish everybody good health, free of Covid, and it will help them if they wear their masks when they rise, 11:55
and we will see you all in about two weeks. Thank you.

THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 28TH JUNE 2022 AT 10:00 A.M.

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