

PRIVATE & CONFIDENTIAL

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

HEARD BEFORE THE INQUIRY PANEL  
ON TUESDAY, 7TH JUNE 2022 - DAY 2

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I N D E X

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CONTINUED OPENING SUBMISSION BY MR. DORAN ..... 5

1           THE INQUIRY RESUMED ON TUESDAY, 7TH JUNE 2022 AS  
2           FOLLOWS:

3  
4           CHAIRMAN: Good morning everybody. Just two very  
5           shorts bits of housekeeping before Mr. Doran continues   10:31  
6           his opening.

7  
8           Can I just remind everybody that 8:30 is the start time  
9           and I'm afraid if you do turn up early, you won't be  
10          able to get in. And if people could leave their           10:31  
11          lanyards rather than take them home, otherwise we're  
12          going to rapidly run out, so leave them on the desk or  
13          leave them at the front reception. Thank you,  
14          Mr. Doran.

15  
16          CONTINUED OPENING SUBMISSION BY MR. DORAN:

17  
18          MR. DORAN: Thank you, Chair. Yesterday I covered the  
19          first five topics in my opening introduction: Core  
20          Participants, background to the Inquiry, legal           10:31  
21          framework and the history of Muckamore Abbey Hospital.  
22          Today I hope to finish my opening. The remaining  
23          topics are: Snapshot of the Hospital today, position  
24          of the Hospital within the health and social care  
25          structure, provisions governing admission, terms of       10:32  
26          reference, witness evidence, production of documents,  
27          history of reporting on the hospital, criminal  
28          proceedings, schedule and conclusion.

1 I should flag up at this stage that topic 9, terms of  
2 reference, and topic 12, history of reporting on the  
3 Hospital, will take considerable time. The other  
4 topics, I will deal with more briefly.

10:32

6 Yesterday I closed my survey of the history of the  
7 Hospital with the observation that patient numbers had  
8 fallen to 41 by August 2021. That leads me on to a  
9 snapshot of the Hospital and its patients today.

10:32

11 I want to look at the physical composition of the  
12 Hospital first. You can see on the screen a  
13 colour-coded map or site plan of the premises. The  
14 Inquiry has also had video footage taken of the  
15 Hospital buildings and the grounds. I'm going to ask  
16 for that footage to be played in a few minutes' time.  
17 Many of those present today will be very familiar with  
18 the Hospital, others may not. I hope that the footage  
19 will assist in setting the scene for the Inquiry. The  
20 footage lasts around nine minutes or so.

10:33

10:33

21  
22 Just before we play the footage, we can have a brief  
23 look at the site plan. The colour-coding indicates the  
24 state of play in May 2020. The areas highlighted in  
25 green are known as the core hospital. These areas are  
26 the Cranfield ward, number 13 on the plan; Six Mile  
27 ward, number 3; the Social Training Centre, number 2;  
28 the Ardmore ward, number 14 - and as we will see in a  
29 moment in the footage, Ardmore is now known as the

10:33

1 Donegore and Killead wards; the Erne Ward, number 4,  
2 which closed in August 2021; the Moyola Day Care ward,  
3 number 17; the community centre, called the Cosy  
4 Corner, number 9; and lastly, the swimming pool, which  
5 is marked number 23.

10:34

6  
7 You can see that the support services and  
8 administration buildings are highlighted in light blue.  
9 The library is located on the right-hand side as one  
10 drives into the Hospital. On the opposite side is the  
11 Administration building, marked number 26. The other  
12 buildings in blue are Estates, number 19; the boiler  
13 house, number 20; the general stores, number 21; the  
14 garages for vehicle repairs, number 22; and the  
15 laundry, number 24.

10:35

10:35

16  
17 The buildings in red show the areas which are now  
18 closed, which are the Greenan ward, marked 5; the  
19 Moylena ward, marked number 6; the Mallow Ward, marked  
20 15; and the Moyle ward, marked 16.

10:35

21  
22 The dark blue buildings are the ones which have been  
23 identified as suitable to be demolished.

24  
25 Finally, you will see some buildings highlighted in  
26 yellow to the top left-hand side of the plan. These  
27 are bungalows and houses which are used for  
28 resettlement. I will come back to the wards in a  
29 moment. First, we are going to play the footage,

10:36

1 which, as I've said, lasts for about nine minutes or  
2 so.

3 CHAIRMAN: Okay.

4  
5  
6 VIDEO FOOTAGE PLAYED TO THE INQUIRY

7  
8 CHAIRMAN: Mr. Doran, can I just mention, for the sake  
9 of transparency, that I have visited, as you know, the  
10 Hospital and the grounds on two occasions; once with  
11 many members, I think, or a number of members of the  
12 counsel team and once with the Panel. Those were  
13 simply familiarisation visits - obviously it's a very  
14 large site - and on the last occasion we went into, I  
15 think, two of the wards. But obviously we didn't  
16 receive any information, other than familiarisation  
17 with the Hospital. Thank you.

18 MR. DORAN: Today, the Hospital provides inpatient  
19 assessment and treatment facilities for adults aged 18  
20 years and over who have severe learning disabilities  
21 and mental health needs, forensic needs or challenging  
22 behaviour. It provides that assessment and treatment  
23 in an acute psychiatric care setting. The Inquiry  
24 asked the trust to provide details of the current  
25 number of patients at the hospital. The total number  
26 of patients at the hospital today is 37.

27  
28 Inpatient assessment and treatment now takes place  
29 across three units on the Hospital site. We can see



1 those units on the map that is now to the right of the  
2 screen. Those buildings contain the following wards:  
3 Cranfield 1, marked 13, is an adult male admission ward  
4 for assessment and treatment of those with a learning  
5 disability and challenging behaviour. Seven patients 10:47  
6 currently reside in Cranfield 1.

7  
8 Cranfield 2, also at 13, provides ongoing treatment for  
9 adult males. Eight patients currently reside at  
10 Cranfield 2. 10:48

11  
12 The Psychiatric Intensive Care Unit Cranfield PICU was  
13 closed in December 2018. At that time, the Trust  
14 stated that ward closure was temporary, to ensure safe  
15 staffing levels across the site. No patients have 10:48  
16 resided there since December 2018.

17  
18 Six Mile, marked 3 on the site plan, provides forensic  
19 services for the assessment and treatment of men with a  
20 learning disability who have been referred by the 10:48  
21 criminal justice system and require low secure  
22 accommodation. Three patients currently reside in the  
23 Six Mile assessment ward and six patients reside in the  
24 treatment ward.

25 10:49  
26 Killead and Donegore, formerly Ardmore, marked 13 on  
27 the site plan, are female admissions wards for  
28 assessment and treatment. Eight patients currently  
29 reside in Killead and five patients reside in Donegore.

1 Patients also have access to the on-site day care  
2 centre, called Moyola, which is marked 17 on the plan.

3  
4 The Inquiry will, of course, be hearing more about the  
5 working arrangements in the Hospital in due course. In 10:49  
6 very general terms, treatment is provided by a core  
7 multidisciplinary team, consisting of psychiatrists,  
8 psychologists, social workers and nurses. Patients can  
9 also be referred to other disciplines, such as  
10 physiotherapy, speech and language therapy, dietetics, 10:50  
11 behavioural services, pediatry, occupational therapy  
12 and therapeutic services. The most recent RQIA report  
13 on the Hospital, dated July 2021, noted that admission  
14 to wards within the Hospital is now significantly  
15 restricted, any decision to admit new patients is risk 10:50  
16 assessed on an individual patient basis, alternative  
17 options must be fully explored before admission is  
18 made.

19  
20 Of course, the Panel will be aware that the broad 10:50  
21 policy objective of resettlement remains in place. As  
22 a result of that policy and the limited number of new  
23 admissions, the patient population is now significantly  
24 lower than before. The current patient profile is very  
25 far removed from that of earlier years of the Hospital 10:51  
26 that I described yesterday afternoon.

27  
28 I hope that this synopsis of the current position at  
29 the hospital will be of assistance to the Panel. The

1 Panel will receive more evidence about that in due  
2 course.

3  
4 I will now look at the position of the Hospital within  
5 the health and social care structure in Northern  
6 Ireland. The Inquiry will be receiving documentation  
7 and hearing detailed evidence about this matter in the  
8 course of its work. There are two basic flowcharts  
9 that may be helpful for illustrative purposes at this  
10 stage. They have been prepared by Inquiry counsel to  
11 assist with the opening. I fully acknowledge that  
12 these are attempts at simplification and will not  
13 capture all of the intricacies of the true position.

10:51

10:51

14  
15 If one looks at the first flowchart, one can see that  
16 overall responsibility for health and social care in  
17 Northern Ireland lies with the Department of Health,  
18 with certain duties delegated to organisations which  
19 report to the Department. Those organisations can be  
20 seen at the second tier of the flowchart.

10:52

10:52

21  
22 The Public Health Agency provides specialist clinical  
23 advice and guidance in relation to the health of the  
24 general population. This includes advising on the  
25 effectiveness of healthcare initiatives, providing  
26 guidance on health protection measures, monitoring  
27 health needs and undertaking work to promote better  
28 health in the population.

10:53

1 The Business Services Organisation provides key  
2 business support right across the health and social  
3 care service. Its functions include paying salaries,  
4 recruitment of new staff, providing legal advice and  
5 procuring supplies and vital equipment. Services were, 10:53  
6 until very recently, commissioned by the Health and  
7 Social Care Board. The Board was dissolved on 31st  
8 March 2022 and, from 1st April 2022, its functions  
9 transferred to a new body. The new body is called the  
10 Strategic Planning and Performance Group, or SPPG, 10:53  
11 which is part of the Department of Health.

12  
13 while services are commissioned by the Strategic  
14 Planning and Performance Group, they are provided by  
15 five health and social care trusts. Muckamore Abbey 10:54  
16 Hospital today, as one can see from the flowchart, is  
17 operated by the Belfast Health and Social Care Trust.  
18 The Belfast Trust was established in April 2007. It is  
19 the largest integrated Health and Social Care Trust in  
20 the United Kingdom. The Inquiry will receive more 10:54  
21 detailed information about the governance, management  
22 and accountability structures of the Belfast Trust at a  
23 later stage. The Inquiry will also wish to hear about  
24 how those structures have evolved over the years. For  
25 present purposes, this is a just a brief synopsis in 10:55  
26 order to assist in understanding where the Hospital  
27 sits within the Trust today.

28  
29 Looking now at the second flowchart, the Trust is

1 managed by a Board of Directors. The Board is made up  
2 of a chairperson, seven non-executive directors, five  
3 executive directors and seven other directors. There  
4 are a further three directors who are not members of  
5 the Trust Board.

10:55

6  
7 The Director For Mental Health and Intellectual  
8 Disability Services is responsible for the efficient  
9 and effective running of all mental health and learning  
10 disability services for the Trust. This, of course,  
11 includes Muckamore Abbey Hospital.

10:55

12  
13 Learning disability services are headed up by a senior  
14 team, which includes a co-director and the Chair of  
15 Division, working alongside professional group leaders  
16 for medical, nursing and social care staff.  
17 Professional leaders are managerially responsible to  
18 the Director For Mental Health and Intellectual  
19 Disability Services, but also report to the executive  
20 director for their professional group on any  
21 profession-specific issues.

10:56

10:56

22  
23 Medical leadership is provided by the clinical  
24 director, who manages all of the medical staff within  
25 the division. Nursing leadership is provided by the  
26 divisional nurse, to whom all nursing staff are  
27 expected to report any professional issues. The  
28 divisional social worker is the professional lead for  
29 all social care staff within the division.

10:56

1 Under the senior divisional team, learning disability  
2 services are managed by service managers, who report to  
3 the co-director. There is a specific service manager  
4 for Muckamore Abbey Hospital who is responsible for the  
5 day-to-day running of the Hospital. That includes all 10:57  
6 of the services that are provided at the hospital,  
7 including inpatient care, day services and outpatient  
8 clinics. The service manager is then supported by  
9 three assistant service managers and together they are  
10 responsible for the delivery of care within the 10:57  
11 Hospital. Now, whilst it is managed by the Belfast  
12 Trust, Muckamore Abbey Hospital provides services to  
13 people with learning disabilities from the Belfast, the  
14 Northern and the Southeastern Health and Social Care  
15 Trust. 10:58

16  
17 I should say, Panel, that the transcript, the site  
18 plan, the footage and, of course, the slides will be  
19 available for all to peruse at their leisure after  
20 today's sessions. 10:58

21 CHAIRMAN: Thank you.

22 MR. DORAN: Before I turn to the Terms of Reference, I  
23 want to touch upon a topic that will require more  
24 focused examination at a later stage in the Inquiry.  
25 This relates to the law on mental health in Northern 10:58  
26 Ireland and, in turn, to the legal basis for admission  
27 of patients to the Hospital.

28  
29 Patients can be admitted on a voluntary basis or

1 detained. The central piece of legislation governing  
2 admission to the Hospital as a detained patient has  
3 been the Mental Health (Northern Ireland) Order 1986.  
4 The 1986 Order contains detailed provisions governing  
5 the care, treatment and protection of persons with a 10:59  
6 mental disorder. The Order distinguishes between  
7 detention in hospital for assessment and detention for  
8 treatment. The Order prescribes detailed criteria that  
9 must be met for admission, founded on examination and  
10 recommendation by a suitably qualified medical 10:59  
11 professional. The Order also contains multiple  
12 provisions governing continued authorisation for  
13 detention and for the discharge of patients. The Order  
14 further provides for the constitution of a Mental  
15 Health Review Tribunal, now known simply as the Review 11:00  
16 Tribunal. Detained patients or their nearest relative  
17 may apply to the Tribunal, which has power to direct  
18 discharge of the patient from hospital.

19  
20 The law in this area is in a state of flux in this 11:00  
21 jurisdiction. I've already mentioned the Bamford  
22 Review and its recommendations for reform of learning  
23 disability services. Another of Bamford 's  
24 recommendations was total reform of mental health  
25 legislation in Northern Ireland. It recommended a 11:00  
26 single comprehensive legislative framework governing  
27 both mental health and mental capacity. It proposed  
28 legislation based on respect for decision-making  
29 capacity, where it exists, regardless of whether a

1 person has a mental health issue.

2  
3 Considerable time was taken to develop the new  
4 legislative framework and in May 2016 the Mental  
5 Capacity Act was enacted by the Northern Ireland 11:01  
6 Assembly. The Act's provisions are being implemented  
7 in phases. Phase 1 implementation took place between  
8 October and December 2019. However, until the Act is  
9 fully commenced, the provisions of the 1986 Order will  
10 continue to operate alongside the provisions of the new 11:01  
11 legislation. Crucially, for our purposes, the 1986  
12 Order was the sole legislation governing admission to  
13 the Hospital until late 2019. Since that time, and  
14 even today, where the critical for admission under the  
15 1986 Order are met, the framework of the 1986 Order 11:02  
16 must be applied. That will continue to be the case for  
17 some time while the new provisions are being introduced  
18 in stages.

19  
20 I do not need to say anything more about these 11:02  
21 provisions for the purposes of the opening. The  
22 Inquiry will have the opportunity to examine the  
23 relevant provisions in greater detail at a later stage.  
24 The Inquiry will also, at an appropriate time, wish to  
25 consider the provisions of the 2016 Act in greater 11:03  
26 detail. The Inquiry will also, of course, wish to be  
27 kept fully informed of the progress of the Act's  
28 implementation.



1 This leads me to the Terms of Reference. I've already  
2 referred to the Terms of Reference and to their  
3 fundamental place in the Inquiry. I'm now going to  
4 look at those terms in some detail. I will pause,  
5 where appropriate, to reflect on how the Inquiry might 11:03  
6 address the various issues raised.

7  
8 The Terms of Reference begin by stating the Inquiry's  
9 core objectives. Those are: To examine the issue of  
10 abuse of patients at Muckamore Abbey Hospital; to 11:03  
11 determine why the abuse happened and the range of  
12 circumstances that allowed it to happen; to ensure that  
13 such abuse does not occur again at Muckamore Abbey  
14 Hospital, or any other institution providing similar  
15 services in Northern Ireland. 11:04

16  
17 It is, I think, helpful to have the core objectives of  
18 the Inquiry set out in such concise terms. The core  
19 objectives remind us that this Inquiry is not only  
20 committed to investigating past abuse, it is also 11:04  
21 charged with the significant responsibility of seeking  
22 to ensure that such abuse does not occur again in the  
23 future.

24  
25 Importantly, the Inquiry must not only investigate what 11:04  
26 happened, it must also determine why it happened and  
27 the range of circumstances that allowed it to happen.  
28 This will, of course, require the Inquiry to receive  
29 evidence from a wide range of sources, both through

1 witness evidence and the receipt of relevant  
2 documentation. I will say more about the Inquiry's  
3 approach to those matters in due course.

4  
5 The next part of the Terms of Reference deals with 11:05  
6 timeframe. Paragraph 2 says that the Inquiry will  
7 report and make findings on events that occurred  
8 between 2nd December 1999 and 14th June 2021. At  
9 first, the date of 2nd December 1999 may appear  
10 artificial. The reason for that date is related to the 11:05  
11 legislation. Section 30(3) of the Inquiries Act 2005  
12 provides that the Minister may not, without the consent  
13 of the Secretary of State, include in the Terms of  
14 Reference anything that would require the Inquiry to  
15 inquire into events during certain specified periods. 11:06  
16 Those periods are (a) before 2nd December 1999 or (b) a  
17 period when devolved government in Northern Ireland is  
18 suspended.

19  
20 Importantly, however, paragraph 3 provides that the 11:06  
21 Inquiry will be able to receive and take account of  
22 evidence outside of the timeframe of the Terms of  
23 Reference where such evidence will assist the Inquiry  
24 in examining, understanding and reporting on matters  
25 within these Terms of Reference. That is very 11:07  
26 important, as otherwise the Inquiry would be precluded  
27 from hearing evidence predating 1999 that may be  
28 capable of assisting it to address the Terms of  
29 Reference. On the other hand, the timeframe cannot

1 simply be ignored. When confronted with evidence  
2 relating to earlier events, the Inquiry would have to  
3 consider carefully whether that evidence should be  
4 received and whether it ought to be taken into account  
5 by the Inquiry.

11:07

6  
7 The next part of the Terms of Reference relates to the  
8 next part of the core objective. It is titled simply  
9 "What Occurred".

11:08

10  
11 Paragraph 4 provides generally that the Inquiry will  
12 examine the nature and extent of abuse of patients at  
13 Muckamore Abbey Hospital.

14  
15 Paragraph 5 goes on to provide a non-exhaustive  
16 definition of abuse. It states that the term "abuse"  
17 may include, but is not restricted to, the following:  
18 (a) physical abuse; (b) sexual abuse; (c) psychological  
19 abuse; (d) mental or emotional abuse; (e) patient  
20 neglect; (f) inappropriate or negligent care; (g)  
21 appropriation of, or improper interference with,  
22 patients' finances or belongings; and (h) other  
23 misbehaviour towards patients.

11:08

11:08

24  
25 The words "may include but is not restricted to" are  
26 significant. It would arguably be quite wrong to adopt  
27 a rigid definition of abuse. The examination of abuse  
28 does not lend itself to a tick-box exercise. The  
29 Inquiry Panel may hear evidence of conduct involving

11:09

1 one of the above forms of abuse or a combination of  
2 different forms of abuse. The Panel may be told about  
3 other forms of misbehaviour that can be characterised  
4 as abusive. Critically, the definition in paragraph 5  
5 is non-exhaustive. It should not be regarded as a 11:09  
6 restrictive provision; rather, it should be regarded as  
7 an aid to identifying the types of conduct that  
8 resulted in this Inquiry being established.

9  
10 Paragraph 6 states that: 11:10

11  
12 "The Inquiry will examine the role of frontline staff,  
13 those with responsibility for clinical and professional  
14 oversight, those with leadership and/or management  
15 responsibilities within the relevant Health Trusts and 11:10  
16 any other relevant persons or bodies in respect of such  
17 abuse. "

18  
19 This paragraph makes it clear that the Inquiry will be  
20 looking at the role of staff at all levels - staff on 11:10  
21 the wards, those with oversight roles and those in  
22 positions of management and leadership. The Inquiry  
23 will not only examine those roles on paper, it will  
24 seek to hear evidence from relevant personnel at all of  
25 those different levels of responsibility. 11:11

26  
27 The Panel will also be aware of the important footnote  
28 to paragraph 6, which says:  
29

1 "Note that all references in this document to the  
2 Health Trusts and other bodies with roles and  
3 responsibilities in respect of health and social care  
4 shall include any precursors of such bodies that  
5 existed within the timeframe of these Terms of  
6 Reference. "

11:11

7  
8 within the Inquiry timeframe there have been  
9 significant structural changes within the healthcare  
10 system. This note makes it clear it that the Inquiry's 11:12  
11 remit extends to the pre-existing authorities, as well  
12 as the present ones.

13  
14 Paragraph 7 provides that:

11:12

15  
16 "The Inquiry will also consider, to the extent  
17 necessary to enable the Inquiry to examine the nature  
18 and extent of abuse of patients, the adherence by staff  
19 and management, the Trusts, the Board and the  
20 Department of Health to relevant statutory obligations, 11:12  
21 the regulatory framework, protocols, policies and  
22 guidance in respect of all aspects of service  
23 delivery. "

24  
25 This paragraph will require the Panel to become 11:12  
26 familiar with the relevant law, protocols, policies and  
27 guidance that govern working practices at the hospital  
28 and that govern the management of the Hospital. It  
29 will also require an understanding of the systems of

1 inspection and regulation. The paragraph invites the  
2 Inquiry to consider the issue of compliance: To what  
3 extent were governing rules, policy and guidance  
4 complied with? Again, that applies to those working at  
5 all levels, from those working on the ground right up 11:13  
6 to those working within the relevant authorities.

7  
8 Paragraph 8 provides that:

9  
10 "The Inquiry will examine the primary and secondary 11:13  
11 causes of such abuse and will address the question of  
12 whether the abuse resulted from systemic failings  
13 within Muckamore Abbey Hospital or the wider healthcare  
14 system in Northern Ireland."

15 11:14  
16 This paragraph makes it absolutely clear that the  
17 Inquiry will not only look at the conduct of  
18 individuals, but will also ask whether there were  
19 broader issues in play that resulted in the need for  
20 this Inquiry. 11:14

21  
22 Looking beyond the conduct of individuals, the Panel  
23 may wish to address questions such as: Was there a  
24 culture within the Hospital that enabled abuse to go  
25 unchallenged? If so, how and why did such a culture 11:14  
26 develop? Were there failings at the level of  
27 management and oversight that contributed to the abuse?  
28 Moving beyond the Hospital itself, were there systemic  
29 failings within our healthcare system that enabled

1 abuse at the hospital to go unchecked? That does not  
2 mean that the Inquiry should undertake a general review  
3 of healthcare provision in this jurisdiction. All  
4 roads along which the Inquiry can travel must lead back  
5 to the Hospital itself. Critically, however, 11:15  
6 paragraph 8 will enable the Panel to examine the  
7 Hospital within the broader context of the system in  
8 which it is located.

9  
10 chair, that might be a suitable time to take a short 11:16  
11 break.

12 CHAIRMAN: Certainly. I think you've got, is it four  
13 sections that you're hoping to conclude today?

14 MR. DORAN: Yes. I can say that I will conclude today.

15 CHAIRMAN: Excellent. Well, thank you. It's much 11:16  
16 cooler in here today, by a simple measure of opening  
17 the windows, but that's a relief to all of us. Thank  
18 you, Mr. Doran. Quarter of an hour? 15 minutes?

19 MR. DORAN: Yes. Shall we say 11:35?

20 CHAIRMAN: Yes, certainly. Fine. Thank you very much. 11:16  
21

22 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:  
23

24 CHAIRMAN: Yes, Mr. Doran.

25 MR. DORAN: The next part of the Terms of Reference 11:36  
26 addresses recruitment, retention, training and support.  
27 Paragraph 9 provides that:

28  
29 "The Inquiry will examine the policies and practices

1 relating to recruitment, retention, training and  
2 support of staff and management at all levels within  
3 the Hospital and, where necessary, within other  
4 facilities offering comparable services. "

11:37

6 The Terms of Reference then move on to deal with the  
7 subject of identifying and responding to concerns.  
8 Those paragraphs, 10 to 13, read as follows:

10 "10. The Inquiry will inquire the adequacy of methods  
11 available to communicate concerns, including  
12 allegations of abuse by staff, patients, relatives and  
13 others about the treatment of patients at the Hospital.

11:37

15 11. The Inquiry will examine the response to such  
16 concerns by frontline staff, those with responsibility  
17 for clinical and professional oversight and those with  
18 leadership and/or management responsibilities within  
19 the relevant Health Trusts, the Health and Social Care  
20 Board, the Public Health Agency and the Department of  
21 Health.

11:38

11:38

23 12. The Inquiry will examine the operation of all  
24 relevant commissioning, supervisory and regulatory  
25 agencies, including, but not limited to, those agencies  
26 specified in paragraph 11 to determine whether, and if  
27 so why, there were failures in the early  
28 identification, investigation and resolution of issues  
29 raised about the treatment of patients. "

11:38



Paragraph 13 reads:

"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 the Hospital were reported to them."

Those paragraphs are largely self-explanatory: when concerns arose, how could those concerns be ventilated? How effective were the responses to those concerns? Significantly, were there failures in the early identification, investigation and resolution of issues raised about the treatment of patients? This last question, in particular, goes beyond the handling of individual complaints; it will require the Inquiry to consider whether there were earlier opportunities missed to detect the issues that were brought to the attention of the relevant authorities when the CCTV footage was uncovered. I will return to this matter when I look at earlier reviews and investigations that have been conducted in respect of the Hospital.

The list in paragraph 13 is not exhaustive. It mentions four organisations specifically, beginning with the PSNI. I've already mentioned, briefly, the remit of the RQIA, which is a Core Participant in this

1 Inquiry. The paragraph also mentions the Patient and  
2 Client Council and the Health and Safety Executive for  
3 Northern Ireland. The PCC was established by the  
4 Health and Social Care (Reform) Act (Northern Ireland)  
5 2009. In broad terms, it is an enabling body, helping 11:41  
6 to articulate the voice of patients and service users  
7 in the planning and delivery of health and social care  
8 services. The PCC interacts and undertakes  
9 consultations with the public to help to ascertain  
10 their views about care services available and also 11:41  
11 about proposed changes. The PCC also liaises with  
12 health and social care organisations to channel the  
13 views of the public. The PCC may also support  
14 individuals who wish to complain about care standards  
15 or who need assistance with expressing their views on 11:42  
16 the provision of services. As I mentioned yesterday,  
17 the PCC played a role in the public engagement  
18 regarding the Terms of Reference of this Inquiry.

19  
20 HSENI is an executive non-departmental body sponsored 11:42  
21 by the Department for the Economy. It was established  
22 in 1999. It is the enforcing authority for health and  
23 safety standards in the workplace in Northern Ireland.  
24 Its remit covers many areas of employment, including  
25 hospitals. Its focus in respect of Muckamore has been 11:42  
26 on regulating the legal duties owed by the Hospital  
27 authorities to the staff working there.

28  
29 There's one further important point to be made in

1 respect of paragraph 13 of the Terms of Reference. The  
2 Inquiry will, of course, be looking at how complaints  
3 of a criminal nature were dealt with historically in  
4 accordance with that paragraph. As the Panel is aware,  
5 however, there is an ongoing police investigation that 11:43  
6 resulted from the recovery of CCTV footage at the  
7 Hospital. There is also, or there are also  
8 prosecutions arising from the investigation. I will be  
9 saying something more about these criminal proceedings  
10 later in my opening statement. Importantly, these are 11:44  
11 ongoing, live proceedings. It goes without saying that  
12 the subject matter of those proceedings is of direct  
13 interest to the Inquiry. The Inquiry will need to be  
14 fully informed of the basis of the evidence within  
15 those criminal proceedings. It will also need to be 11:44  
16 fully informed of the progress of those proceedings.  
17 Importantly, however, the Inquiry will not be examining  
18 how those ongoing proceedings are being managed by the  
19 PSNI and the PPS.

20  
21 As I will discuss in greater detail later, the Inquiry  
22 entered into a Memorandum of Understanding with the  
23 PSNI and the PPS in March of this year. The MoU is  
24 published on the Inquiry website. The MoU sets out how  
25 the Inquiry, the PSNI and the Inquiry -- and the PPS, 11:45  
26 I'm sorry, are going to manage their respective  
27 responsibilities as the criminal proceedings and the  
28 Inquiry move forward.  
29

1 Paragraph 17 of the MoU states:

2  
3 "The subject matter of the investigation and  
4 prosecutions is of direct interest to the Inquiry, but  
5 the Inquiry is not examining the response of the PSNI 11:45  
6 and the PPS that has followed from the seizure of the  
7 CCTV footage."

8  
9 So, to summarise, the Inquiry will be examining how  
10 complaints arising from the Hospital have been managed 11:46  
11 historically by the police and prosecuting authorities,  
12 but this does not apply to the current criminal  
13 investigation and prosecutions. And as I've said, I  
14 will be coming back to that matter later.

15 11:46  
16 Returning to the text of the Terms of Reference.  
17 Paragraphs 14 to 17 address a number of discrete  
18 issues. I do not propose to elaborate on those issues  
19 at this stage.

20 11:47  
21 Paragraph 14 relates to the installment of CCTV at the  
22 Hospital. The Inquiry will examine the effects of  
23 installment, operation and use of CCTV at Muckamore  
24 Abbey Hospital.

25 11:47  
26 Paragraph 15 deals with safeguards, mechanisms and  
27 policies regarding other patients:

28  
29 "The Inquiry will examine the safeguards, mechanisms

1 and policies in place to ensure that patients were not  
2 subject to abuse or other disturbing behaviour by other  
3 residents/patients and whether those controls and  
4 policies were sufficient. "

11:47

5  
6 Paragraph 16 addresses resettlement:

7  
8 "The Inquiry will examine the adequacy and workings of  
9 the policy and process of discharge and resettlement of  
10 patients of Muckamore Abbey Hospital. "

11:48

11  
12 Paragraph 17 raises the wider issue of resourcing:

13  
14 "The Inquiry will consider the adequacy of financial  
15 resources to ensure:

11:48

16  
17 (a) appropriate numbers, skills, quality and training  
18 of staff;

19  
20 (b) appropriate care, treatment and accommodation for  
21 patients with mental health conditions and/or learning  
22 disabilities treated or cared for at Muckamore Abbey  
23 Hospital. "

11:48

24  
25 I have already touched on the legal and regulatory  
26 framework. This is dealt with specifically in  
27 paragraphs 18 and 19. Paragraph 18 states:

11:48

28  
29 "The Inquiry will examine the following:

1 (a) the relevant primary and secondary legislation;

2  
3 (b) the regulatory framework;

4  
5 (c) any relevant codes, policies, guidelines, reports 11:49  
6 and other documentation relating to management,  
7 administration and working practice at Muckamore Abbey  
8 Hospital and, where necessary, of other comparable  
9 facilities. "

10  
11 And paragraph 19 states:

12  
13 "The Inquiry will consider the adequacy of the above to  
14 provide a framework to prevent abuse of patients with  
15 mental health conditions or learning disability in 11:49  
16 Muckamore Abbey Hospital and other such settings in  
17 Northern Ireland. "

18  
19 I've mentioned some of the relevant legislation and I  
20 have referred, in passing, to the regulatory framework. 11:50  
21 As I will be explaining shortly, the Inquiry is  
22 currently receiving documentation from many different  
23 sources. This will include codes, policies,  
24 guidelines, reports and suchlike. The counsel team  
25 will, in due course, collate all material of this kind 11:50  
26 for the Panel and Core Participants in order that this  
27 aspect of the Terms of Reference can properly be  
28 addressed.  
29

1 Paragraphs 20 to 22 address matters of practice and  
2 procedure. Paragraph 20 echos Section 17 of the  
3 Inquiries Act 2005 that I mentioned yesterday  
4 afternoon:

5  
6 "The Inquiry Chair will determine how the Inquiry is  
7 conducted, including the procedure, the nature of  
8 evidence and calling of witnesses to the Inquiry."  
9

11:51

10 Paragraph 21 provides:

11:51

11  
12 "Aspects of practice and procedure may be governed by  
13 protocols to be established at the outset of the  
14 Inquiry."  
15

11:51

16 And as I've already mentioned, to date the Inquiry has  
17 published protocols relating to production and receipt  
18 of documents, Core Participants, funding of legal  
19 representation and redaction, anonymity and Restriction  
20 Orders. And those protocols have been augmented, where  
21 necessary, by Chair's statements. All of this material  
22 is published on the Inquiry's website.  
23

11:52

24 Paragraph 22 refers to witness services:

11:52

25  
26 "Appropriate witness services will be made available in  
27 the course of the Inquiry."  
28

29 And that is important. I will return to the matter of

1 support for witnesses later when I have finished with  
2 the Terms of Reference.

3  
4 The final part of the Terms of Reference relates to the  
5 report and recommendations. The three paragraphs read 11:52  
6 as follows:

7  
8 "23. The Inquiry will submit its report to the Minister  
9 of Health. The Inquiry may make findings on matters  
10 within the Terms of Reference as outlined above, 11:52  
11 including the issue of abuse and whether such abuse  
12 resulted from systemic failings."

13  
14 Paragraph 24:

15 11:53  
16 "Having regard to, and dependent on, those findings,  
17 the Inquiry will make recommendations in respect of the  
18 following:

19  
20 (a) the core objective of ensuring that any such abuse 11:53  
21 and any such failings do not recur at Muckamore Abbey  
22 Hospital or at any other facility providing similar  
23 services in Ireland;

24  
25 (b) improvement of the training of staff and management 11:53  
26 at Muckamore Abbey Hospital and comparable facilities;

27  
28 (c) improvement of management, policies, systems and  
29 processes within Muckamore Abbey Hospital, including



1 those relating to whistleblowing and corporate  
2 governance;

3  
4 (d) improvement of competence, quality and internal  
5 governance of the Board of such hospitals; 11:54

6  
7 (e) to the extent that it is necessary and appropriate,  
8 the role of wider adult social care services and the  
9 relevant health and social care bodies (including, but  
10 not limited to, the Health and Social Care Trusts, the 11:54  
11 Health and Social Care Board, the Public Health Agency  
12 and the Department) in ensuring the safety of patients  
13 and best practice in service delivery at Muckamore  
14 Abbey Hospital and comparable facilities;

15 11:54  
16 (f) the legal and regulatory framework and related  
17 matters;

18  
19 (g) the requirement or desirability of the provision of  
20 redress to meet the particular needs of victims of 11:55  
21 abuse within Muckamore Abbey Hospital. "

22  
23 **Paragraph 25:**

24  
25 "The Inquiry Chair may, if necessary and appropriate, 11:55  
26 issue an interim report or reports with  
27 recommendations. "

28  
29 As we embark on the Inquiry, the report and

1 recommendations may appear to be beyond the horizon.  
2 Paragraph 5 is, however, worth noting, and you  
3 mentioned it specifically yesterday, Chair --  
4 CHAIRMAN: Paragraph 25.  
5 MR. DORAN: Sorry? 11:55  
6 CHAIRMAN: Paragraph 25?  
7 MR. DORAN: Paragraph 25.  
8 CHAIRMAN: You said 5.  
9 MR. DORAN: Oh, sorry. Paragraph 25 is worth noting.  
10 It affords you, Chair, with the discretion to issue an 11:56  
11 interim report with recommendations. And that is  
12 obviously an option that you will wish to keep under  
13 review at all times as the Inquiry proceeds.  
14  
15 I'm conscious that it has taken some time to cover the 11:56  
16 Terms of Reference. They are wide ranging. There are  
17 multiple issues to be addressed. The Inquiry will, of  
18 course, be mindful of the need to adopt a proportionate  
19 approach to its work where that is appropriate. The  
20 nature of the issues that have given rise to this 11:56  
21 Inquiry clearly required the timeframe to be an  
22 extended one. It was also important that the Inquiry's  
23 work should not be confined to a narrow fact-finding  
24 exercise. The core issue of abuse cannot be examined  
25 in isolation from the context and structures within 11:57  
26 which it occurred. Recommendations to improve future  
27 practices, procedures and structures cannot properly be  
28 made without a sound basis in evidence. The Inquiry  
29 will need to draw upon a significant body of evidence

1 and information in order to discharge its  
2 responsibilities.

3  
4 It is, however, worth sounding a slight note of caution  
5 at this point. The Terms of Reference do indeed cover 11:58  
6 multiple issues, but the core objectives must always be  
7 kept in plain view. The Inquiry will need to adopt a  
8 suitably proportionate approach to the issues in order  
9 to complete its work within a reasonable timeframe. It  
10 would be virtually impossible to pursue every single 11:58  
11 line of inquiry that will arise from the evidence in  
12 the same degree of detail. As the Inquiry moves  
13 forward, it will have to make decisions as to where its  
14 resources will most effectively be channelled. It  
15 would be quite wrong to be prescriptive about this at 11:59  
16 the beginning of the Inquiry. I am raising the matter  
17 now as counsel to the Inquiry because it is important  
18 to be realistic about what the Inquiry can achieve.

19  
20 The Inquiry will hear from as many people as possible 11:59  
21 who were affected by the events at Muckamore. The  
22 Inquiry will also hear from staff, the various  
23 organisations and public authorities that are connected  
24 to the Hospital or that have an interest in the  
25 Hospital. Individuals, patient groups, and indeed the 12:00  
26 relevant authorities will have their own particular  
27 concerns and their own particular priorities. They  
28 will naturally wish those concerns and priorities to be  
29 addressed by the Inquiry. The Inquiry will, of course,

1 be responsive to matters that are raised by Core  
2 Participants and by others with an interest in the  
3 Inquiry's work. The Inquiry does, however, have a  
4 wider responsibility to deliver on the core objectives  
5 within a reasonable time.

12:00

6  
7 It is also to be remembered that the role of a Core  
8 Participant is wider than the Core Participant's own  
9 particular interest. Core Participants have a role in  
10 furthering the work of the Inquiry and assisting it in  
11 fulfilling its Terms of Reference. Therefore, I trust  
12 that everyone involved in the Inquiry will understand  
13 that not every single matter raised by them will be  
14 capable of being explored to an equivalent degree.

12:01

15  
16 I have looked in detail at the Terms of Reference, I  
17 now want to consider what the Inquiry will need in  
18 order to address those Terms of Reference.

12:01

19  
20 The Inquiry will be assisted both by witnesses  
21 providing evidence to the Inquiry and by individuals  
22 and organisations providing relevant materials to the  
23 Inquiry. As regards both witnesses coming to give  
24 evidence and as regards the provision of documents, the  
25 Inquiry intends to rely on voluntary cooperation, where  
26 possible.

12:01

12:02

27  
28 Having said that, as I outlined earlier in the opening,  
29 the Chair of a Public Inquiry is vested with important

1 powers to compel the attendance of witnesses to give  
2 evidence and to compel the production of documents.

3 I'll just pause for a moment. (Short pause)

4 CHAIRMAN: Thank you.

5 MR. DORAN: In the Inquiry protocol on the production 12:03  
6 and receipt of documents, that is Protocol No. 1, dated  
7 10th November 2021, it is made clear that the Chair  
8 will exercise those compulsory powers if that should  
9 become necessary. Paragraph 18 of that protocol reads:

10 12:03  
11 "The Chair will exercise his powers under Section 21 to  
12 obtain relevant documents where, for example, a request  
13 is refused, the response to a request is incomplete,  
14 there has been no response to a request by a stated  
15 deadline or a delay is requested which appears to the 12:03  
16 Chair not to be reasonable. Some document providers  
17 may be facilitated in their production of documents by  
18 receipt of a Section 21 Notice, whether in general  
19 terms or in respect of certain documents or categories  
20 of document. Such document providers should alert the 12:04  
21 solicitor to the Inquiry promptly."

22  
23 It has not been necessary, to date, for the Chair to  
24 issue a Section 21 in the face of resistance, although  
25 understandably, some document providers have requested 12:04  
26 the issue of a Section 21 Notice in order to facilitate  
27 them in the production of documents. Such notices have  
28 been issued accordingly. Many documents will be of a  
29 personal and sensitive nature. The notice provides a

1 clear and unambiguous legal basis for the production of  
2 such documents to the Inquiry.

3  
4 similar principles will be at play as regards witness  
5 evidence. It is anticipated that voluntary cooperation 12:05  
6 will be the norm, but resort to compulsory powers will  
7 be considered where that is necessary to enable the  
8 Inquiry to do its work.

9  
10 very soon after the establishment of the Inquiry, you, 12:05  
11 Chair, encouraged engagement with the Inquiry by those  
12 who had relevant information to provide. An early  
13 notice issued on the Inquiry's website read as follows:

14  
15 "One of the Inquiry's core objectives is to examine the 12:05  
16 issue of abuse and neglect of patients at Muckamore  
17 Abbey Hospital. It is important that we hear from as  
18 many people as possible about their experience of  
19 Muckamore Abbey Hospital, regardless of when it  
20 occurred or what information they want to give. At 12:06  
21 this stage we are interested in hearing from anyone who  
22 feels that they have information that the Inquiry  
23 should consider, whether they are a current or former  
24 patient, a relative, a carer, a current or former  
25 member of staff, or a member of the public who 12:06  
26 witnessed events at Muckamore and whether they had a  
27 negative or positive experience of Muckamore. We need  
28 your help to conduct our Inquiry fairly and fully."  
29

1 That message was reinforced in engagement sessions that  
2 were held to promote and publicise the work of the  
3 Inquiry. The message was also reiterated in Chair's  
4 statements on the website. More recently, you, Chair,  
5 have issued a similar invitation by way of a local 12:07  
6 radio announcement. It may be that the opening of the  
7 Inquiry will prompt others with relevant information to  
8 come forward.

9  
10 Witnesses were asked to fill in a short contact form in 12:07  
11 the first instance. The form asks witnesses to provide  
12 basic details about their connection with Muckamore and  
13 the kind of information that they may have to give. To  
14 date, 126 individuals have made contact with the  
15 Inquiry in this way. The Inquiry has appointed Cleaver 12:08  
16 Fulton Rankin Solicitors to take statements from those  
17 witnesses who have relevant evidence to give. That  
18 work is being undertaken by a statement team. The team  
19 has received training in working with witnesses who may  
20 be vulnerable or who may be anxious. Where necessary, 12:08  
21 the team has access to specially appointed registered  
22 intermediaries who can assist witnesses in  
23 communicating. The intermediaries can also be called  
24 upon to assist witnesses when they are giving their  
25 evidence. 12:09

26  
27 There will also be witness support available throughout  
28 the hearings to ensure that witnesses have the support  
29 that they need. As you have indicated Chair, if anyone

1 needs to speak to a witness supporter, they can easily  
2 identify them, as they will be wearing a yellow lanyard  
3 within this chamber. During hearings, they will be in  
4 the back row of the public gallery. The support  
5 services we have in place have been sourced directly by 12:09  
6 the Inquiry, but they are, of course, totally  
7 independent of the Inquiry. If, for any reason,  
8 someone cannot find the witness support person who is  
9 attending, they should ask a member of the Inquiry team  
10 and the member of the team will find that person for 12:09  
11 them.

12  
13 Up to today's date, the statement team has been in  
14 contact with 111 witnesses. The team has taken  
15 statements from 40 individuals. That figure includes 12:10  
16 some statements that have been completed but not yet  
17 formally signed. Some of those witnesses are scheduled  
18 to give evidence in the final week of this month and in  
19 the first week of July. A provisional schedule for  
20 those weeks will be issued very soon to Core 12:10  
21 Participants. I'm going to say something a little bit  
22 more about those evidence sessions later in the  
23 opening.

24  
25 Beyond this first phase of evidence, the Inquiry 12:10  
26 intends to hear, also, from staff, ranging from  
27 frontline staff to those in positions of management and  
28 leadership. The Inquiry will also seek evidence from  
29 relevant persons within the various authorities that



1 have responsibility for the organisation, management,  
2 oversight and inspection of the Hospital. The Inquiry  
3 may also seek assistance from independent expert  
4 witnesses where it appears necessary to do so. This  
5 will be an incremental process. Core Participants will 12:11  
6 be kept fully informed of progress as the Inquiry  
7 proceeds with its work.

8  
9 Before I leave the topic of witnesses, I want to draw  
10 attention to the undertaken given by the Director of 12:12  
11 Public Prosecutions. You mentioned that undertaking in  
12 your opening remarks, Chair. The undertaking is dated  
13 6th June. It is worth rehearsing the precise wording.  
14 The undertaking reads as follows:

15 12:12  
16 "1. No oral evidence given by a natural person before  
17 the Inquiry will be used in evidence against that  
18 person in any criminal proceedings, or for the purpose  
19 of deciding whether to bring such proceedings, save as  
20 provided in paragraph 3 herein. 12:12

21  
22 2. No written statement drafted for the purpose of  
23 giving evidence to the Inquiry by or for such a person  
24 identified at paragraph 1 will be used in evidence  
25 against that person in any criminal proceedings or for 12:13  
26 the purpose of deciding whether to bring such  
27 proceedings, save as provided in paragraph 3 herein.  
28 This shall include any statement made by or for such a  
29 person for that purpose preparatory to giving evidence

1 to the Inquiry or during the course of their testimony  
2 to the Inquiry."

3  
4 And then paragraph 3 states:

5  
6 "Paragraphs 1 and 2 do not apply to:

7  
8 (a) a prosecution in which that person is charged with  
9 having given false evidence in the course of this  
10 Inquiry or having conspired with or procured others to 12:13  
11 do so; or

12  
13 (b) a prosecution in which that person is charged with  
14 any offence under Section 35 of the Inquiries Act 2005  
15 or with having conspired with or procured others to 12:14  
16 commit such an offence."

17  
18 I mentioned Section 35 yesterday afternoon, Chair. And  
19 the undertaking is, I understand, available on the  
20 Inquiry's website. 12:14  
21

22 I want to make four observations on the undertaking.  
23 First, undertakings of this kind are frequently given  
24 in the context of public inquiries. Prominent recent  
25 examples are the Historical Abuse Inquiry and the 12:14  
26 Grenfell Tower Inquiry.

27  
28 Secondly, it is very important not to confuse an  
29 undertaking of this kind with immunity from

1 prosecution. It is, categorically, not an immunity.  
2 It prevents the use of evidence given to the Inquiry in  
3 criminal proceedings, it does not shield an individual  
4 from criminal proceedings that are instituted on the  
5 basis of evidence other than evidence given to the 12:15  
6 Inquiry.

7  
8 Thirdly, as you have indicated, Chair, the effect of  
9 the undertaking is, effectively, to deprive an  
10 individual of the evidential protection of the 12:15  
11 privilege of self-incrimination at the Inquiry. This  
12 privilege is preserved in the Inquiry context by  
13 Section 22 of the Inquiries Act 2005. The undertaking  
14 means that a person cannot say 'I will not speak to the  
15 Inquiry, because that might leave me open to criminal 12:16  
16 charges'. Because of the undertaking, that would not  
17 be a legitimate basis on which to refuse to give  
18 evidence or to refuse to answer questions when giving  
19 evidence.

20 12:16  
21 Fourthly, and critically, the rationale for seeking an  
22 undertaking of this kind is to ensure that the Inquiry  
23 will hear from the widest possible spectrum of  
24 witnesses. Put simply, the absence of the undertaking  
25 would make it more difficult for the Inquiry to achieve 12:17  
26 its core objectives.

27  
28 Chair, I'm wondering if that might be a suitable time  
29 to break for lunch today?

1 CHAIRMAN: Yes, you've warned me that you might want to  
2 stop a bit early today. But you're still satisfied, as  
3 I understand it, that you will finish today? would it  
4 be sensible to start rather earlier than two o'clock,  
5 say quarter to? 12:17  
6 MR. DORAN: 1:45 would be perfect, Chair, yes.  
7 CHAIRMAN: 1:45?  
8 MR. DORAN: Yes.  
9 CHAIRMAN: All right. well, it's a slightly extended  
10 lunch break, but provided we're going to get you done, 12:17  
11 as it were, in the afternoon, that will be absolutely  
12 fine. All right, thank you very much.  
13 MR. DORAN: Thank you.  
14 CHAIRMAN: Can I just mention that the undertaking  
15 which you have just referred to, there is an area on 12:17  
16 the website for it to go up and it will be going up in  
17 fact at lunch today. It couldn't go up earlier because  
18 apparently it mucks up the streaming. But it will be  
19 there.  
20 MR. DORAN: Thank you for that clarification. 12:18  
21 CHAIRMAN: Thank you very much. Thank you.  
22  
23 THE INQUIRY THEN ADJOURNED FOR LUNCH AND RESUMED AS  
24 FOLLOWS:  
25 12:18  
26 CHAIRMAN: Thank you.  
27 MR. DORAN: Chair, I can confirm that the transcript of  
28 yesterday's hearing and the undertaking given by the  
29 DPP have both been posted on the Inquiry's website.

1 CHAIRMAN: Indeed they have. Thank you.

2 MR. DORAN: I return to the issue of production of  
3 documents to the Inquiry. This process remains  
4 ongoing. I've referred to the timeframe of the  
5 Inquiry, which extends back to 1999. I've also  
6 referred to multiple organisations and authorities with  
7 a connection to Muckamore, or with responsibilities  
8 touching on Muckamore, including the Belfast Trust and  
9 other Trusts, the Department, the RQIA and the PCC.

13:49

10  
11 In addition to those authorities, the professional  
12 regulatory bodies have handled complaints arising from  
13 the Hospital. Representative bodies will have provided  
14 assistance to persons subject to disciplinary  
15 proceedings. The PSNI and PPS will have been involved  
16 in handling complaints of a criminal nature. Patients  
17 from Muckamore will have been resettled at a range of  
18 locations.

13:50

19  
20 These are just examples of organisations and  
21 authorities that may be in possession of material that  
22 will assist the Inquiry. "Document provider" is the  
23 shorthand term we have been using to describe  
24 organisations and authorities of that kind.

13:50

25  
26 The Inquiry has contacted 73 different potential  
27 document providers within the last six months. The  
28 Inquiry has obtained details of documents held by them  
29 that may assist the Inquiry. The process of having

13:51

1 documents produced to the Inquiry is, as I have said,  
2 ongoing. You, Chair, have also directed that all  
3 material that may be relevant to the Inquiry's work  
4 must be retained by the relevant authorities and must  
5 not be destroyed.

13:51

6  
7 This exercise is onerous and time-consuming. It is  
8 important that I should acknowledge the work that is  
9 being conducted by the document providers and their  
10 representatives to assist the Inquiry in this regard.  
11 It is also important that I should emphasise the need  
12 to ensure that this exercise is conducted in a  
13 proportionate, properly organised and properly targeted  
14 manner.

13:52

15  
16 In a large scale exercise of this nature, care is  
17 needed to ensure that the Inquiry's focus is not  
18 distracted by an avalanche of material that is  
19 peripheral to the issues that the Inquiry must  
20 consider. The Inquiry team has spent considerable time  
21 engaging with the various document providers to  
22 identify the material that needs to be obtained. The  
23 material that is obtained then requires to be assessed  
24 to determine whether it will in fact assist the Inquiry  
25 in addressing its Terms of Reference. Prior to  
26 disclosure to Core Participants, material may need to  
27 be redacted - for example, I've referred to the orders  
28 that you have made, Chair, that require redaction of  
29 personal details and that grant anonymity to patients,

13:52

13:52

13:53

1 unless that anonymity is waived.

2  
3 As you said yesterday, Chair, one possible approach to  
4 adopt would be to wait until all of this work is  
5 completed before starting the oral hearings. You have, 13:53  
6 understandably, decided that such an approach would  
7 unduly delay the important public-facing work that the  
8 Inquiry must undertake. I have mentioned the lengthy  
9 wait that patients, their families, friends and carers  
10 have had for this Inquiry. I have also emphasised the 13:54  
11 forward-looking aspect of the Inquiry, the need to  
12 ensure that abuse does not occur in the future at the  
13 Hospital or at any comparable facility in Northern  
14 Ireland. Having regard to those considerations, it was  
15 imperative that the Inquiry should move on to the stage 13:54  
16 of oral hearings at the earliest opportunity.

17  
18 One consequence of that is that Core Participants will  
19 not, at this early stage, have received disclosure of  
20 documents. They ought not to feel in any way 13:54  
21 disadvantaged by that. The work on obtaining documents  
22 and preparing documents for disclosure will continue.  
23 Core Participants will, of course, be updated on  
24 progress and will receive material on an ongoing basis.

25 13:55  
26 The Inquiry counsel team has prepared a preliminary set  
27 of documents for the Panel. That preliminary set of  
28 documents will be shared with Core Participants very  
29 shortly, although there are some of the documents that

1 remain to be redacted. Some further time will be  
2 needed before those particular documents can be shared.

3  
4 Another consequence of this approach is that the  
5 Inquiry is not going to retrieve records and other 13:55  
6 documents relating to a particular patient before a  
7 witness can come along and speak to the Inquiry about  
8 that patient's experience. As witnesses make their  
9 statements and give evidence, the Inquiry team will  
10 constantly monitor what records and other material the 13:56  
11 Inquiry will need to obtain in relation to the patient  
12 concerned. The Inquiry will strive to ensure that no  
13 one is disadvantaged by this approach.

14  
15 If records are later produced that the Inquiry thinks 13:56  
16 the witness should be asked about or should have the  
17 opportunity to comment on, the necessary arrangements  
18 will be made for that to happen. If there is a  
19 particular situation in which the Inquiry feels that  
20 some records simply must be retrieved before a witness 13:57  
21 gives their account, the Inquiry can adapt its  
22 appropriate accordingly.

23  
24 The objective, therefore, is to hear what witnesses  
25 have to say at the earliest opportunity, while 13:57  
26 remaining alert to matters arising in the course of  
27 their evidence that might need to be further explored.

28  
29 I am now going to move on to the topic of history of



1 reporting on Muckamore Abbey Hospital. I've looked at  
2 the background to the Inquiry, the Terms of Reference  
3 and the work that is being done to enable the Inquiry  
4 to address its Terms of Reference. I now want to  
5 mention some previous investigations and reports that  
6 relate to Muckamore.

13:58

7  
8 In the course of the oral evidence, the Inquiry will  
9 hear about individual complaints and how they were  
10 dealt with. It will also hear about disciplinary  
11 proceedings and criminal proceedings that have arisen  
12 as a result of complaints at the Hospital. As I have  
13 mentioned, the Inquiry will also be considering the  
14 work of the RQIA and its predecessor, the Mental Health  
15 Commission. That work has resulted in multiple  
16 inspection reports. The Inquiry has been gathering in  
17 those reports and, where relevant, they will be made  
18 available to Core Participants in due course.

13:58

19  
20 Going beyond these individual cases and individual  
21 inspection reports, however, there have also been a  
22 number of exercises aimed at addressing broader or  
23 systemic issues affecting the patient experience and  
24 the management of the Hospital. I want to review those  
25 exercises at this stage, as I anticipate that they will  
26 be mentioned frequently in the course of the hearings.

13:58

13:59

13:59

27  
28 The first exercise that I want to address dates back to  
29 2013. This was the Ennis Ward adult safeguarding

1 investigation. The investigation was prompted by  
2 concerns raised by a care assistant employed by a  
3 private care provider. She was working on the ward as  
4 part of an induction programme for patients who were  
5 moving to a care home managed by the private provider. 14:00  
6 The care assistant alleged that, while working on the  
7 ward in November 2012, she witnessed staff being  
8 physically and verbally abusive to four named patients.  
9 The safeguarding investigation was established on  
10 receipt of the allegations. This was led by a 14:00  
11 designated officer from outside the Hospital, who was  
12 assisted by two social workers from the Trust's  
13 Community Learning Disability Team. As some of the  
14 allegations were of a criminal nature, the  
15 investigation was carried out jointly by the Trust and 14:01  
16 the PSNI.

17  
18 As well as the care assistant who initially raised the  
19 concerns, other employees of the private care provider  
20 also then expressed concerns about conduct that they 14:01  
21 had witnessed during shifts at the Hospital. As a  
22 result of these allegations, three staff members - that  
23 is, two nurses and a healthcare assistant and a student  
24 nurse - were placed on precautionary suspension. The  
25 nurses were referred to the Nursing and Midwifery 14:01  
26 Council and the Assistant to the Disclosure and Barring  
27 Service.

28  
29 I'm not going to delve into the detail of the

1 investigation. The investigation report was produced  
2 in October 2013. As a result of the PSNI  
3 investigation, a nurse and a healthcare assistant were  
4 charged with assault and ill-treatment. The nurse was  
5 acquitted. The healthcare assistant was found guilty 14:02  
6 of one count of common assault, which was subsequently  
7 overturned on appeal. The healthcare assistant  
8 retired. And there was also a disciplinary process  
9 conducted in respect of the nurse.

10  
11 The Inquiry will have the opportunity to consider the  
12 Ennis investigation and the materials generated by the  
13 investigation in due course. There are four reasons  
14 for drawing attention to the Ennis report at this  
15 stage. 14:02

16  
17 First, the concerns that triggered the investigation  
18 fall squarely within the Inquiry's Terms of Reference.  
19 I would refer the Panel in particular to the  
20 non-exhaustive definition of abuse at paragraph 5. The 14:03  
21 allegations encompassed both verbal and physical abuse.

22  
23 Secondly, the concerns went beyond a single allegation  
24 of assault perpetrated by a single individual on a  
25 single patient. The concerns related to four staff, 14:03  
26 four patients and encompassed multiple allegations.

27  
28 Thirdly, the concerns were the subject of investigation  
29 by the Trust and by PSNI.

1 Fourthly, the concerns were the subject of multiple  
2 case conferences and strategy meetings in the months  
3 after the concerns were first voiced. As a result,  
4 various steps were taken, aimed at improving staffing  
5 levels, improving the living environment and enhancing 14:04  
6 patient support on the ward.

7  
8 The Inquiry will no doubt wish to examine the  
9 out-workings of the Ennis review carefully. The issue  
10 of identifying and responding to concerns is integral 14:04  
11 to the Terms of Reference. There are, in fact, three  
12 fundamental and closely related questions arising from  
13 the Ennis episode that the Inquiry may wish to  
14 consider, albeit with the benefit of hindsight: First,  
15 can it be said that the evidence considered in the 14:05  
16 course of that review was possibly indicative of a  
17 wider culture of abuse within the Hospital? Secondly,  
18 given the nature of the allegations, were the  
19 investigation and the response sufficiently  
20 far-reaching and robust? Thirdly, was this a missed 14:05  
21 opportunity to detect and to address the very problems  
22 that are now the subject of this Inquiry?

23  
24 The second report that I want to address, at this  
25 stage, is the report of November 2018 titled "A Review 14:06  
26 of Safeguarding at Muckamore Abbey Hospital: A Way to  
27 Go." This report postdated the allegations of abuse  
28 that surfaced in 2017.

1 In January 2018, the Belfast Trust commissioned an  
2 independent review team, chaired by Dr. Margaret Flynn,  
3 to examine safeguarding issues at the hospital between  
4 2012 and 2017. Dr. Flynn had previously led a serious  
5 case review into abuse at Winterbourne View private  
6 hospital in Gloucester in 2012. The review's broad  
7 remit was to identify the principal factors responsible  
8 for the historic and recent safeguarding incidents at  
9 the Hospital. The review examined safeguarding files,  
10 RQIA reports and Health and Social Care Board  
11 information from the relevant period. The team  
12 interviewed patients, families and staff and  
13 representatives of the RQIA.

14:06

14:07

14 Again, I'm not going to go into the review in detail  
15 for the purpose of the opening, the Panel will have the  
16 opportunity of considering its work and its findings in  
17 due course. I would just like to flag up some of the  
18 themes that emerge from the review that this Inquiry  
19 will have the opportunity of exploring in greater  
20 depth.

14:07

14:08

23 First, the review commented on the fact that the RQIA  
24 inspection process tended to be word-specific and,  
25 therefore, did not present an overarching view of the  
26 Hospital. As the review commented, a hospital is more  
27 than the sum of its wards.

14:08

28  
29 Secondly, the review commented on inconsistencies and

1 gaps in records relating to safeguarding events and  
2 concluded that it could not be determined how closely  
3 adult safeguarding practice accorded with operational  
4 safeguarding procedures.

5  
6 Thirdly, on the question of culture, the review  
7 observed:

8  
9 "There was, indeed, a culture, a tolerated set of norms  
10 or work practices which were harmful and  
11 disproportionate. It was shaped by the use of power,  
12 relationships and place in which the wards were closed.  
13 Visitors, relatives, as well as professionals were  
14 advised whether or not they could visit due to  
15 'unsettled patients'. Individual staff members were  
16 comfortable working with certain staff and cut and  
17 paste records concerning the use of seclusion, for  
18 example, were not challenged."

19  
20 Fourthly, the review also contrasted that culture with  
21 valued practice. The report recorded the wish of  
22 families for it to be known that there were some staff  
23 who conscientiously provide compassionate care and  
24 treatment. That is, of course, important. In the  
25 engagement sessions that have been conducted by the  
26 Inquiry, you, Chair, have emphasised that the Panel  
27 will wish to hear of experiences, both good and bad,  
28 positive and negative. Just as abusive conduct on the  
29 part of some must be investigated, so too must

1 diligence and care on the part of others be recognised.

2  
3 Fifthly, the report questioned the use of "seclusion"  
4 and commented:

5  
6 "Current scrutiny of seclusion would suggest that the  
7 use of seclusion was not benign in all circumstances."  
8

9 Sixthly, the report commented on the frequent use in  
10 safeguarding files of the term "has a history of making  
11 allegations". The review questioned whether the use of 14:11  
12 that term might risk the assumption being made from the  
13 outset that an allegation lacks credibility. The  
14 review also considered whether perhaps too much was  
15 expected of patients with learning difficulties in 14:12  
16 terms of identifying the times or dates when incidents  
17 may have occurred. The team envisaged a much more  
18 proactive role for advocacy to ensure that the voice of  
19 the patient was heard.

20  
21 Seventhly, the report highlighted delays in discharge  
22 and commented:

23  
24 "The Hospital is plagued by mental health delayed  
25 discharges; that is, although a clinical 14:12  
26 multidisciplinary decision has been made that a patient  
27 is ready to be discharged and the patient is safe to be  
28 discharged, the Hospital's delayed discharges are  
29 compromising its capacity to provide assessment and

1 treatment. While the reasons behind the delayed  
2 discharges are multifactorial, patients subjected to  
3 protracting waiting for non-acute hospital provision  
4 are likely to deteriorate."

14:13

6 This is, by necessity, a selective survey of the way to  
7 Go findings. There may be other aspects of the report  
8 that the Inquiry and Core Participants will wish to  
9 examine. There may be aspects of the report with which  
10 some will take issue. I hope, however, that I have  
11 fairly represented the tenor of the report and  
12 identified some of the key themes that will be of  
13 interest to the Inquiry.

14:13

15 That, then, leads me to the third report in this  
16 sequence. This report is titled "A Review of  
17 Leadership and Governance at Muckamore Abbey Hospital"  
18 and it's dated 31st July 2020. This report was  
19 produced by an independent review team commissioned by  
20 the Health and Social Care Board and Public Health  
21 Agency at the request of the Department of Health. The  
22 remit was to review leadership and governance  
23 arrangements within the Belfast Trust between 2012 and  
24 2017. The team was also asked to consider the degree  
25 to which those arrangements may have contributed to the  
26 abuse of vulnerable patients going undetected. The  
27 Department of Health sought this further review  
28 because, in its view, the Way to Go report had not  
29 sufficiently addressed matters of leadership and

14:13

14:14

14:14



1 governance.

2  
3 The review examined a range of Trust documents and  
4 conducted meetings with a range of individuals and  
5 authorities. The team identified the Ennis ward 14:15  
6 concerns, the incidents revealed by the CCTV footage of  
7 2017 and the handling of a specific complaint in 2017  
8 as key events in its review. This is a very detailed  
9 report. Again, I do not propose to drill into the  
10 detail. It is, however, worth highlighting a number of 14:15  
11 the key findings.

12  
13 First, the Trust had extensive governance systems in  
14 place, but their complexity hindered the ability to be  
15 responsive. 14:16

16  
17 Secondly, there was an apparent disconnect between the  
18 governance arrangements in place at Trust level and  
19 what was occurring on the ground at the Hospital. High  
20 level strategies and leadership frameworks did not 14:16  
21 result in good practice at the Hospital. To quote the  
22 report:

23  
24 "The review team concluded that there was a culture  
25 within MAH of trying to resolve matters on site. The 14:16  
26 location of MAH at some distance from the Trust and the  
27 lack of curiosity about it at Trust level caused the  
28 review team to view it as a place apart. Clearly, it  
29 operated outside the sight lines and under the radar of

1 the Trust."

2  
3 Thirdly, the team found the leadership team at the  
4 Hospital to be dysfunctional. The report identified a  
5 lack of continuity and stability at directorate level 14:17  
6 and a lack of interest and curiosity at board level.  
7

8 Fourthly, the report concluded, bluntly, that these  
9 failings resulted in harm to patients. The team  
10 concluded that while senior managers at MAH may not 14:17  
11 have been aware of the culture of abuse, their  
12 responsibility for providing safe and compassionate  
13 care remained. The review team also acknowledged the  
14 more recent efforts of the Trust to promote and monitor  
15 a safe, person-centred environment at the Hospital. 14:18  
16 The report made 12 recommendations directed at the  
17 Department of Health, the Health and Social Care Board  
18 and the Public Health Agency and the Trust.  
19

20 A public inquiry will, by its very nature, require a 14:18  
21 broader and more penetrating investigation than would  
22 have been possible in any of the three review processes  
23 that I have mentioned. The Inquiry will not, of  
24 course, be bound by the conclusions of those previous  
25 reviews. It will have the benefit of the evidence and 14:18  
26 material presented to those reviews and it will, where  
27 appropriate, revisit the matters addressed in  
28 accordance with the Terms of Reference.  
29

1 As I have mentioned, the concerns that gave rise to the  
2 Ennis review emerged in 2012. Before I complete this  
3 section of the opening, I'm going to go further back in  
4 time and flag up an earlier episode for the attention  
5 of the Inquiry. The beginning of this episode predates 14:19  
6 the Terms of Reference. As I have indicated, however,  
7 paragraph 3 of the Terms of Reference permits the  
8 Inquiry:

9  
10 "To receive and take account of evidence outside of the 14:19  
11 timeframe where such evidence will assist the Inquiry  
12 in examining, understanding and reporting on matters  
13 within these Terms of Reference."

14  
15 I should say that the Inquiry is still in the process 14:20  
16 of obtaining all relevant material relating to this  
17 episode. I simply want to provide a broad outline of  
18 what occurred at this stage for contextual reasons.  
19 The Inquiry and Core Participants will be in a position  
20 to analyse the relevant events in appropriate detail in 14:20  
21 due course.

22  
23 In 1996 a former patient of the Hospital made  
24 allegations that he had been sexually abused by other  
25 patients at the Hospital and one member of staff. The 14:20  
26 allegations related to a period predating the Terms of  
27 Reference from 1970 to 1982. The allegations were  
28 referred to the DPP, but there was no prosecution. The  
29 case was also the subject of civil proceedings that

1 ultimately resulted in a civil settlement in 2004.

2  
3 Subsequent to that, the Eastern Health and Social  
4 Services Board, one of the Boards that amalgamated to  
5 become the HSCB, appointed a review group to undertake 14:21  
6 a fact-gathering review of all clinical records  
7 relating to the care of the complainant while he was at  
8 Muckamore. The review group had a representative from  
9 the Board and the North and West Belfast Trust. It was  
10 chaired by the Assistant Director of Legal Services in 14:22  
11 the Central Services Agency. The review group was also  
12 asked to identify any other salient information arising  
13 from this review relating to activity of a similar  
14 nature involving any other patients in the care of the  
15 Hospital from in or around 1971 to 1986. In addition 14:22  
16 to that, the group was asked to identify and document  
17 other sources of potentially relevant information that  
18 might require further exploration.

19  
20 The review group undertook a review of records relating 14:22  
21 to the complainant and other patients. They extracted  
22 what they described as "the most significant entries in  
23 which staff have documented inappropriate behaviour  
24 between patients and other entries which may be  
25 relevant." They also highlighted that some records 14:23  
26 were missing and others difficult to decipher. They  
27 also advised that it was difficult to identify which  
28 members of staff had made the various entries in the  
29 records.

1 The review group reported their findings to the Board  
2 in November 2005. The work of the group did not end at  
3 that point and it went on to review further files in  
4 addition to those covered by the initial exercise.  
5 Some of the records identified by the review in the 14:23  
6 course of its work dated back to the early 1960s.

7  
8 That was not the end of the matter. The results of  
9 this process were referred to the PSNI. The PSNI then  
10 undertook a phased investigation into the matters that 14:24  
11 had been identified by the review group. The  
12 investigation was conducted in and around 2006 to 2008.  
13 The investigation was primarily focused on alleged  
14 incidents between patients that had been identified in  
15 the records by the review group. 14:24

16  
17 As I have said, the Inquiry and Core Participants will  
18 have the opportunity of analysing the relevant material  
19 in due course.

20 14:24  
21 It appears that the investigation did not ultimately  
22 result in prosecutions for a variety of reasons,  
23 including, first, the historical nature of the  
24 allegations and the consequent loss of forensic  
25 opportunities; secondly, the lack of supporting 14:25  
26 evidence; and thirdly, in some instances, the lack of  
27 capacity of alleged victims to be interviewed.

28  
29 Aside from the PSNI investigation, the Eastern Health

1 and Social Services Board and the North and West  
2 Belfast Trust also conducted a review of policies and  
3 procedures to safeguard children and vulnerable adults  
4 in Muckamore Abbey Hospital. This review team was  
5 chaired by the Director of Hospital and Community 14:25  
6 Learning Disability Services. The group produced a  
7 report in December 2005 that "set out current practice  
8 at Muckamore Abbey Hospital which seeks to ensure that  
9 children and vulnerable adults are safe during their  
10 stay at the Hospital." The report included a number of 14:26  
11 recommendations that were aimed at improving  
12 safeguarding practices within the Hospital.

13  
14 Again, it is not necessary for me to go into the finer  
15 detail of that report for the purpose of my opening 14:26  
16 statement.

17  
18 It is important to draw attention, at this stage, to  
19 these earlier reviews in 2005 and to the police  
20 investigation that followed. The allegations that were 14:26  
21 being investigated were, for the most part, different  
22 in character to the more recent allegations of abuse  
23 perpetrated by staff on patients. Nonetheless, the  
24 allegations gave rise to serious safeguarding concerns.  
25 There was an awareness of those concerns at a high 14:27  
26 level within the relevant public authorities at the  
27 time.

28  
29 In determining why the abuse happened and the range of

1 circumstances that allowed it to happen, as required by  
2 the Terms of Reference, the Inquiry will need to  
3 consider carefully the response of the authorities to  
4 those earlier allegations: Ought those earlier  
5 allegations to have prompted a root and branch review 14:27  
6 of policy and practice at the Hospital? Ought there to  
7 have been more radical intervention at that point in  
8 time? What was the reason for decisions taken at that  
9 point in time? Were decisions that ought to have been  
10 taken not taken? Again, was this an earlier missed 14:28  
11 opportunity to consider deep-seated cultural issues  
12 within the Hospital which were later identified in the  
13 Way to Go report?

14  
15 Chair, I'm going to move on shortly to deal with the 14:28  
16 present criminal proceedings. I think this would be an  
17 appropriate time to take a short break. I will then  
18 have a fairly short closing sequence.

19 CHAIRMAN: Shall we say quarter to?

20 MR. DORAN: Yes, that's very helpful. 14:29

21 CHAIRMAN: Does that give you enough time?

22 MR. DORAN: Oh, yes indeed. Thank you, Chair.

23 CHAIRMAN: And just to say, I'm not giving the five  
24 minute warning when we have these short breaks, I'm  
25 afraid it's up to you to make sure that you are nearby 14:29  
26 when the gong goes. But I do, obviously, in the  
27 morning and after the lunch adjournment.

28  
29 Then in the break, if you could just confirm the order

1 in which Core Participants are going to address us. It  
2 may be you know that already, but I just want to make  
3 sure we know who is speaking when.

4 MR. DORAN: I'll confirm that after the break.

5 CHAIRMAN: Thank you very much. Okay, thank you.

14:29

6  
7 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

8  
9 CHAIRMAN: Thank you.

10 MR. DORAN: Chair, I will confirm the order of play for  
11 the rest of this week later in my opening.

14:46

12 CHAIRMAN: Okay, thank you.

13 MR. DORAN: I'm now going to move on from past reviews  
14 to other significant processes that are going on at  
15 present.

14:46

16  
17 The allegations of abuse at the Hospital that first  
18 came to public attention in late 2017 are the subject  
19 of an ongoing police investigation and prosecutions.  
20 There are two preliminary points to be made about this  
21 investigation: First, the subject matter of the  
22 investigation - that is, allegations of abuse at the  
23 Hospital - falls squarely within the Inquiry's Terms of  
24 Reference; secondly, and importantly, the remit of the  
25 Inquiry extends significantly beyond the incidents that  
26 are being investigated.

14:47

14:47

27  
28 When announcing the Inquiry in the Assembly on 8th  
29 September 2020, the Minister commented:



1 "We must take account of the ongoing major police  
2 investigation, because I want to ensure that any  
3 process that is put in place does not jeopardise this  
4 investigation. "

14:47

5  
6 The Inquiry itself has taken steps to ensure that its  
7 work does not jeopardise the investigation. A  
8 Memorandum of Understanding was agreed following  
9 consultations between the Chair of the Inquiry, the  
10 Police Service of Northern Ireland and the Public  
11 Prosecution Service for Northern Ireland. The MoU is  
12 dated 9th March 2022 and is published on the Inquiry's  
13 website.

14:48

14  
15 The PSNI investigation to date has been primarily  
16 focused on Cranfield Psychiatric Intensive Care Unit,  
17 or PICU to use the acronym. PICU was a secure unit for  
18 patients with learning disabilities who presented a  
19 risk of harm to themselves or others. Patients were  
20 either detained under the Mental Health Order or  
21 admitted on a voluntary basis. Only patients and staff  
22 had access to the ward. The ward was staffed primarily  
23 by healthcare support workers and staff nurses.

14:48

14:49

24  
25 CCTV was installed in the Hospital in or around early  
26 2017, including a number of cameras being installed  
27 within PICU. The system was tested in March 2017 and  
28 was, it appears, mistakenly left operational. The  
29 system was recording in the period before it was

14:49

1 officially due to go live. The fact that the system  
2 was recording was not known to staff on the ward. This  
3 was discovered in September 2017, after it was reported  
4 to PSNI that a PICU patient, Aaron Browne, had been  
5 assaulted by a staff member. The patient's father,  
6 Glynn, whom I have mentioned, raised concerns that he  
7 had not been informed about the incident at the time  
8 that it had occurred. Mr. Browne requested that the  
9 CCTV be checked. It became apparent, then, that the  
10 CCTV had in fact been operative and footage of the  
11 incident had, in fact, been captured.

14:50

14:50

12  
13 If I could just have one moment, Chair? (Short pause)

14  
15 Thank you, Chair. As I said, it became apparent that  
16 the CCTV had in fact been operative and footage of the  
17 incident had in fact been captured. This discovery  
18 prompted further examination of the footage. In the  
19 first instance, the Trust dip-sampled the footage and  
20 this revealed further evidence of abuse committed by  
21 staff on PICU patients. The footage was then subject  
22 to review by senior social workers and designated adult  
23 protection officers appointed from outside the Hospital  
24 staff. The Trust referred 143 incidents to police  
25 relating to PICU, involving eight patients and 90 staff  
26 members between March and September 2017.

14:51

14:51

14:52

27 Subsequently, in February 2019, PSNI seized the  
28 entirety of the footage, reviewed the footage and noted  
29 728 incidents in the course of that review. Given the

1 large scale of the investigation, PSNI decided that  
2 suspects would be split into groups for the purposes of  
3 police investigation and prosecution.

4  
5 PSNI submitted its first investigation file to the PPS 14:53  
6 on 10th April 2020. That file related to seven staff  
7 and alleged offences committed against eight patients.  
8 The reported offences included common assault,  
9 ill-treatment, wilful neglect, false imprisonment,  
10 fraud and forgery of notes and misconduct in public 14:53  
11 office.

12  
13 On 6th April 2021, the PPS confirmed that a decision  
14 had been taken to prosecute those seven individuals in  
15 relation to alleged ill-treatment of patients at the 14:53  
16 hospital. A further staff member was added to the  
17 first file in August 2021, as the staff member in  
18 question had similar shift patterns to the other  
19 suspects. Those cases are before the Magistrates  
20 Court, with committal proceedings yet to take place. 14:54

21  
22 A second file, relating to eight staff members on PICU  
23 was submitted in late 2020. A third file, relating to  
24 nine suspects was submitted in June 2021. A fourth  
25 file has also been submitted. 14:54  
26

27 This is an ongoing investigation. Arrests continue to  
28 be made. On 19th May it was reported that the 34th  
29 arrest had been made in connection with this

1 investigation. There may be further arrests, there may  
2 be further prosecutions.

3  
4 The live nature of these ongoing criminal proceedings  
5 is fully acknowledged in the Memorandum of 14:55  
6 Understanding. The MoU sets out a shared understanding  
7 of how the Inquiry, the PSNI and the PPS will discharge  
8 their respective responsibilities as the Inquiry, the  
9 investigation and the prosecutions move forward.

10 14:55  
11 I do not need to go through the MoU in detail for the  
12 purpose of the opening, the document is available on  
13 the website. I do, however, want to draw attention to  
14 some of its key features.

15 14:56  
16 Paragraphs 16 to 18 enshrine the Inquiry's basic  
17 commitment to respecting the integrity of the  
18 investigation, while at the same time getting on with  
19 the work required to address the Terms of Reference.  
20 Those paragraphs read as follows: 14:56

21  
22 "16. The Chair of the Inquiry acknowledges the need to  
23 make every effort to ensure that the work of the  
24 Inquiry does not impede, impact adversely on or  
25 jeopardise in any way the PSNI investigation into abuse 14:56  
26 at the Hospital and the prosecutions that result from  
27 that investigation.

28  
29 17. The subject matter of the investigation and

1 prosecutions is of direct interest to the Inquiry, but  
2 the Inquiry is not examining the response of the PSNI  
3 and the PPS that has followed from the seizure of the  
4 CCTV footage.

5  
6 18. The Chair, in accordance with Section 17(1) of the  
7 Act, shall make every effort to ensure that the  
8 procedure and conduct of the Inquiry respects the  
9 integrity of the investigation and prosecutions, while  
10 continuing to address its Terms of Reference. "  
11

12 Given the importance of the subject matter of the  
13 investigation and prosecutions to the Inquiry, the MoU  
14 provides that the Inquiry will be provided with  
15 material relating to the investigation. Documents  
16 relating to the ongoing criminal proceedings will not  
17 be disclosed to Core Participants without reasonable  
18 notice having been given to the PSNI and the PPS.  
19 Where the PSNI or PPS adopt the view that there would  
20 be a risk of disclosure impeding, adversely impacting  
21 on or jeopardising the criminal proceedings, they may  
22 ask the Chair to make an order restricting what can be  
23 disclosed. The Chair will have due regard to the live  
24 nature of the investigation when determining such  
25 applications.  
26

27 where material is not disclosed, there is provision for  
28 Core Participants to be provided with a summary or gist  
29 of the material in question. This will ensure that

1 Core Participants are properly informed of the  
2 Inquiry's ongoing work, while at the same time  
3 respecting the autonomy of the criminal proceedings.

4  
5 The MoU also provides for the viewing of the CCTV 14:59  
6 footage under restricted conditions by the Inquiry  
7 Panel. The first phase of that viewing is scheduled  
8 for next week. Importantly, paragraph 41 of the MoU  
9 provides that:

10  
11 "The Chair of the Inquiry, in consultation with the 14:59  
12 PSNI and the PPS, will keep under review the matter of  
13 whether wider viewing of the CCTV footage on behalf of  
14 Core Participants may be appropriate or necessary,  
15 while at all times making every effort to ensure that 14:59  
16 the integrity of the investigation and the prosecutions  
17 is protected."

18  
19 Paragraph 43 restates a recurring theme within the MoU:

20  
21 "In considering any issue relating to the viewing of 15:00  
22 CCTV footage, the Chair will have particular regard to  
23 the live nature of the investigation and any ongoing or  
24 prospective prosecutions."

25  
26 The MoU includes detailed provisions on witness 15:00  
27 statements and the giving of oral evidence to the  
28 Inquiry. Those provisions are also designed to ensure  
29 that the Inquiry can conduct its work in parallel with

1 the criminal proceedings and in such a way as to avoid  
2 hampering the criminal proceedings. Within the MoU,  
3 there is also a mechanism for resolving any issue that  
4 appears to give rise to a risk of the criminal  
5 proceedings being jeopardised.

15:01

6  
7 That is all I need to say at this stage about the  
8 criminal proceedings.

9  
10 Before I finish my opening remarks, Chair, I want to  
11 mention, briefly, the schedule from now until the  
12 summer recess. Representatives of Core Participants  
13 will be addressing the Panel tomorrow, Thursday and  
14 first thing Monday. Tomorrow's hearing will be  
15 starting at 2:00 p.m. and the Panel will hear from

15:01

16 Mr. Andrew McGuinness on behalf of the Department of  
17 Health. And the opening statement on behalf of the  
18 Department of Health will be followed by the opening  
19 statement on behalf of the PSNI, which will be

15:01

20 presented by Mr. Mark Robinson QC. There is a 10:30  
21 start on Thursday morning and the first Core  
22 Participant to provide an opening statement on Thursday  
23 will be the Trust, and that will be presented by  
24 Mr. Joseph Aiken QC. The Trust's opening statement  
25 will be followed by the opening statement on behalf of  
26 the RQIA, given by Mr. Michael Neeson. At 2:00 p.m. on  
27 Thursday the Panel will hear the closing statement on  
28 behalf of the unaffiliated Core Participants --

15:02

29 CHAIRMAN: It should be the opening, I think.

15:02

1 MR. DORAN: Did I say closing? wishful thinking,  
2 Chair!

3 CHAIRMAN: Yes, two o'clock Thursday.

4 MR. DORAN: Two o'clock Thursday. That's for the  
5 unaffiliated Core Participants represented by O'Reilly 15:03  
6 Stewart. And that statement will be given by  
7 Mr. Connor Maguire QC.

8 CHAIRMAN: Yes.

9 MR. DORAN: Then the final opening statement will be  
10 given on Monday morning at 10:00 a.m. by 15:03  
11 Monye Anyadike-Danes QC on behalf of individuals  
12 affiliated to Action For Muckamore and individuals  
13 affiliated to the Society of Parents and Friends of  
14 Muckamore Abbey.

15 15:04

16 So, that's the running order for the next few days.  
17 And that timetable has, I think, been formally issued  
18 to all.

19

20 As I've mentioned, next week has been set aside for the 15:04  
21 closed viewing by the Panel of the CCTV footage. The  
22 Inquiry intends to have seven days of witness evidence  
23 at the end of June and the beginning of July. The  
24 first day of oral evidence will be on Tuesday, 28th  
25 June. The Inquiry will also sit on Wednesday 29th and 15:04  
26 Thursday 30th June and then again from Monday 4th July  
27 to Thursday 7th July. And the hearings will then  
28 resume in September on a date to be fixed.  
29



1 As you have said, Chair, the questioning of witnesses  
2 will be conducted by Inquiry counsel. Core  
3 Participants will be issued later this week with a  
4 document that sets out the timetable for witness  
5 statements to be provided to Core Participants and for 15:05  
6 Core Participants to propose questions to Inquiry  
7 counsel in advance of a witness' evidence. And there  
8 is also a form on which the proposed questions must be  
9 submitted. The actual schedule for those hearing days  
10 will be issued at the earliest possible opportunity. 15:05  
11 CHAIRMAN: Yes.  
12 MR. DORAN: Now, It is, of course, a matter for Core  
13 Participants as to whether they wish to propose  
14 questions for a witness. It should be borne in mind  
15 that this first phase of evidence is all about the 15:06  
16 patient experience. The witnesses will have made their  
17 statements. Inquiry counsel will try to assist those  
18 witnesses in telling their stories to the Inquiry.  
19  
20 It may be that the procedure for proposing questions 15:06  
21 will be utilised more extensively at a later stage of  
22 the Inquiry when we come to hear from those in  
23 positions of responsibility within the Hospital and  
24 within the various relevant authorities. I do not, of  
25 course, wish to discourage questions being proposed - 15:06  
26 it's entirely a matter for Core Participants and their  
27 representatives to decide what, if any, questions they  
28 wish to propose to Inquiry counsel - I just want to  
29 emphasise that this first phase of evidence is devoted

1 to the evidence of people affected by the events at  
2 Muckamore; it is for them to come and tell the Inquiry  
3 about their experience or the experience of someone  
4 close to them.

5  
6 Chair, that brings me to the conclusion of my opening.  
7 I would like to thank my counsel team for their  
8 assistance and support in the preparation of these  
9 opening remarks. I'm very grateful to the Panel and to  
10 all of the others in attendance for bearing with me  
11 over the past day and a half. I've covered a wide  
12 range of topics. We shall, of course, be returning to  
13 those topics in varying degrees of detail in the months  
14 ahead.

15  
16 Panel, finally, my counsel team and I look forward to  
17 assisting you throughout the course of the Inquiry  
18 hearings. Thank you.

19 CHAIRMAN: Well, Mr. Doran, thank you very much indeed.  
20 You've managed to be both concise and comprehensive, so  
21 we're very grateful.

22  
23 I think to add to your programme, there is going to be  
24 training tomorrow morning at 11 o'clock in this room  
25 for those who are going to be using CaseView. So, the  
26 room will be available to you and there will be  
27 somebody -- some of you may already know how to use  
28 CaseView, but it may be worth attending in any event to  
29 make sure everything is actually working properly.

1 I also want to thank our AV technicians, because in  
2 fact, given that these are the first two days of the  
3 Inquiry, it's, if I may say so, a masterful art of  
4 getting everything up and running as they have. And  
5 also, thanks to our stenographer; it's extremely useful 15:09  
6 to have CaseView and to be able to follow what's  
7 happening on screen. But it is an arduous job doing  
8 it, as I know, so thank you very much to her.

9  
10 Could I ask that we have the room cleared in the next 15:09  
11 sort of ten minutes, because I need to come in and do  
12 various things. But in the meantime, thank you very  
13 much indeed. Those who want to attend tomorrow for  
14 training at 11 o'clock, please. Otherwise we'll start  
15 at 2:00. Thank you very much indeed. 15:09

16 MR. DORAN: Thank you, Chair.

17  
18 THE INQUIRY WAS THEN ADJOURNED UNTIL WEDNESDAY, 8TH  
19 JUNE 2022 AT 2:00 P. M.  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29

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