MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 13TH JUNE 2022 - DAY 5

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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INDEX

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

CHAIRMAN: Morning. Thank you. Good morning, Mr. Doran.

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

The Panel will then go into closed session this afternoon for viewing of CCTV footage, and that viewing is scheduled to take place on Monday to Thursday of this week. The Inquiry is not sitting on Friday and is not sitting next week.

Oral evidence is then due to commence on Tuesday, 28th June, and a schedule for the oral evidence will be issued later this week.

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

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

DSO; the Belfast Trust is represented by the Directorate of Legal Services or DLS; and the RQIA is represented by a separate solicitor representative within the DLS. So, I just wanted to clarify that matter before we commence this morning. 10:03

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

MR. DORAN: Thank you, Chair.

CHAIRMAN: Yes. Thank you. Ms. Anyadike-Danes. 10:03

SUBMISSION BY MS. ANYADIKE-DANES

MS. ANYADIKE-DANES: Thank you. Things fall apart. The centre cannot hold. For decades Muckamore Abbey Hospital was the centre for the assessment and 10:03 treatment of severe learning disabilities and mental health needs in Northern Ireland. It did not hold. As a result, hundreds of vulnerable people and their families were harmed and were deprived of the chance to live their best lives. 10:04

Alternatively, and aptly put by Mr. Aiken for the Belfast Health and Social Care Trust, a system relies on people, it relies on people to do the right thing at the right time, and when that does not happen then the 10:04 system will fail. For my clients, the system did fail and their loved ones were abused.

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

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

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

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

Without exception all of them suffered abuse, whether sexual, physical, emotional or financial. Some of this is captured on CCTV and we understand forms part of the PSNI's Operation Turnstone. Other abuse were the subject of complaint and may be involved in what Mr. Robinson for the PSNI referred to in his opening as the previous responses to complaints and previous investigations. 10:06

We also represent those trainees who went to Muckamore for training and work experience. They will give evidence as to what they saw and the impact it made on them. Suffice it to say that so far as they are concerned it did not reflect the values of the Belfast Trust to which Mr. Aiken referred to in his opening. 10:06

I'll say something about those experiences later, and of course the detail will be the subject matter of their evidence to this Inquiry. Nevertheless at this stage it is worth noting that the collective experience of our clients with Muckamore spans from 1950 to this present day, a period of 72 years, which is very nearly the entire life of Muckamore itself. We have clients whose loved ones were admitted as children, a practice that continued until 2010 when the services provided in Muckamore's Mallow Unit were replaced by the newly opened Iveagh Centre. 10:06 10:07

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

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

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

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

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

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

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

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

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

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The core aims and objectives of AFM were, from the outset, to raise awareness of the abuse scandal at Muckamore and to demand answers and accountability. They assist distressed families by flagging services to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Importantly, the report noted that:

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

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

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

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

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

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

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

administrative exercise.

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

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

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

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

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

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

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

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

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

For some of their loved ones this had disastrous

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

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

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

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

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

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

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

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

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

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

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

This is not new for Muckamore.

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

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

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

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

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

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

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

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

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

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

although only a summary was published in February 2019.

The "A Way to Go" Report, which I'm sure the Panel has read, and many here have, is damning. Paragraph 55 states that: 10:40

"Between April 2012 and September 2017, the Hospital recorded 128 allegations concerning staff working on PICU, Six Mile, Killead, Ennis, Oldstone, Greenan, Cranfield, Mallow, Donegore, Moylena and Erne." 10:40

Over 92 of these allegations concerned physical abuse, and 102 (80%), concerned physical abuse combined with institutional abuse, psychological abuse, verbal abuse and psychological/emotional abuse. Thus, the most 10:41 typical type of allegation concerning staff is physical abuse. That's typically what happened amongst a catalogue of abuse. It is a grim catalogue of abuse. Even so, it deals only with recorded allegations. And our clients fear that not all allegations were 10:41 recorded. Many of them have loved ones on those wards at that time and they complained of abuse. Still others were on those wards at earlier times, outside the scope of this Inquiry, and they also made complaints, and they now know, from the Way to Go 10:41 Report, that at least for PICU, the CCTV shows patients being harmed by staff and yet no safeguarding referrals were made. Yet no members of staff spoke out. And that's what concerns them. No safeguarding referrals

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

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

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

10:43

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

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

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

MS. ANYADIKE-DANES: I very much hope so. That's my intention.

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

MS. ANYADIKE-DANES: Thank you.

10:45

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

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

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

That short break that you gave - or the short extension I think to the break, I'm very grateful for. There was an issue to be resolved and it's a correction I need to make, and if you've got a correction to make it's best 11:07
to make it as soon as possible, so I'm doing that now.
CHAIRMAN: Yes. Quite.
MS. ANYADIKE-DANES: I had referred to Mr. Doran, who obviously is senior counsel for the Inquiry, as having effectively endorsed the complex governance and 11:08
structural arrangements by saying they were comprehensive and appropriate. That wasn't Mr. Doran's language, that was the language of the Review and Leadership in Governance of Muckamore Abbey Hospital

Report of 2020. That was their language. Mr. Doran referred to that report, but he wasn't himself claiming that that is something that should be attributable to the structure. So I thought I'd correct that immediately. 11:08

CHAIRMAN: Indeed. Thank you.

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

CHAIRMAN: Yes. Thank you very much indeed.

MS. ANYADIKE-DANES: So, so far, what I was -- what I have been dealing with is the betrayal element, not only the framework that gave rise to expectations, the expectations that were had and then what happened. I now want to move on to a section that I've called "the silenced". 11:08

The current Chief Executive of the Trust, Dr. Cathy Jack, made a video statement on 5th August 2020, after the publication of that very report I've just referred to, the Leadership and Governance Review, and it is cited in detail by Mr. Aiken in his opening for the Trust, but it includes these words: 11:09

"The CCTV has given a voice to our patients and tells their story that they could not tell themselves." 11:09

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

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

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

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

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

seclusion room, which our client insisted on being shown. Whilst the reference to "rape" was something that she had knowledge of as she had been sexually assaulted in the community shortly before her admission to Muckamore.

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

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

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

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

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

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

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

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

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The importance of that cannot be overstated because it now seems to them that the real issue was not whether our clients' loved ones could give voice to the abuse they suffered, but whether that communication would be regarded as credible and whether their relatives and 11:15 friends who raised concerns on their behalf would be believed.

We know, for example, that many claims of abuse were prematurely dismissed by staff in Muckamore due to 11:15 alleged concerns about the credibility of those claims. Many of our clients noticed bruising on their loved ones' bodies, or even broken toes, and when asked for an explanation they were routinely told it was clumsiness or self-harm. Such an explanation - and 11:15 this was the real difficulty with it - such an explanation was inherently plausible, because some of them simply could not comprehend that their vulnerable loved ones would be harmed in a hospital where they had been taken to for help. So if they were told, 'well 11:16 that bruise happened because they dropped down, had a seizure or they but bumped into something', they were predisposed almost to believe that. Who could conceive that that was intentionally inflicted or allowed to be

inflicted?

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

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

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

Our clients also found that not only was a suggestion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. A veneer of governance.

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

3. Complicity of a dysfunctional management system.

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

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

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

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

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

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reality of what is actually going on.

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

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

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

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The Trust's response to the Ennis Ward allegations was subsequently criticised in the 2020 Review, Leadership and Governance Review, as a missed opportunity to address what they considered was institutional abuse as the matter was not escalated. The 2020 Review 11:30
considered that this should have been addressed at the time as an SAI and a formal complaint, and that review concluded the problem was not in governance processes, but rather in people's response to working in a closed environment with its own norms and values and with 11:30
loyalty to the group rather than the patients or their employing Trust.

So, what about the second component, a place apart? We say this is also necessary for this culture of impunity 11:31
to develop. That closed environment. The 2020 Review concluded that Muckamore was a self-contained community with its own culture and identity being viewed by the Trust as a place apart. This cultural autonomy was, however, toxic to the point of being almost incestuous. 11:31
The Way to Go Report highlighted that some staff were related, including from some families who had worked there for generations, constraining the possibility of true peer challenge. This review belatedly recorded

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

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

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

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

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

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

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

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

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

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

Our patients hope that the Inquiry will identify the constraints on discharge, the causes of delay, and how, in practice, that can be addressed in the interest not just of their loved ones who remain in Muckamore

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

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

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

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

More disturbingly still, an internal Trust e-mail dated

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

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

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

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

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

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

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

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

So, now I want to deal with the final part of this opening on behalf my clients, and it's called the response.

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

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

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One client, whose son spent years in Muckamore, would speak to him on the phone twice a day, come what may. Taking him home as often as she could, she consistently challenged staff in the face of unexplained bruises found on her son, pressed for dental treatment when her 11:42
son's pain had not been addressed, did all his washing all the time he was in Muckamore, and finally took him home in the face of the risk that she would be unable to see him due to the Covid-19 pandemic. The impact on the family of that has been significant, with her 11:42
partner having to take unpaid leave and eventually resigning his employment to help and support their son at home. That's a very significant commitment. All the while you're campaigning.

11:42

In another case, a family of a patient looked after him at home until he was 21 - he's the youngest of eight - and whilst at home and before his admission, the family looked after him and provided him with proper family life willingly and lovingly. They revolved their lives 11:43
around him. This continued when he was admitted to Muckamore in 1988. His mother feared that without regular visits, due to his memory issues he would become isolated and would forget his family. His

siblings, the eldest of whom is a client, responded, and they made a rota to make sure that he had visitors daily and experienced the love of his family. This has continued for the last 34 years. And they are now using all means possible, including litigation, to secure his discharge so that they can bring him home. 11:43

CHAIRMAN: I'm so sorry to interrupt you, but I just notice that on the Inquiry's screens - and this will be happening in the Hearing Room B as well - we are seeing images of what I assume are your clients. 11:43

You'll remember that I made a general restriction order in relation to anonymity. Of course if they wish to do that, they can waive that anonymity, and can I assume - I just need it on the record - that in relation to all those whose images that we are going to be seeing, they have waived the anonymity in relation to the general restriction order? 11:44

MS. ANYADIKE-DANES: Yes, you can. You can, Chair.

CHAIRMAN: Sorry to interrupt you. Thank you very much. 11:44

MS. ANYADIKE-DANES: You can.

So, that loving care, that keeping him insofar as you can, a person who is not physically with you, in your family and making him know that he is part of your family, that is a dedication willingly embarked on that has continued for 34 years, and will continue, they tell me, until they bring him home. 11:44

In addition to such daily acts of love and devotion, our clients had the courage and the conviction to step up and speak out for their loved ones in the face of this insidious scandal. Their response was threefold: 11:45
Organising campaign, continue their own oversight for those still in Muckamore, and press for resettlement.

I think it is important to remember these are ordinary people. Ordinary people, ordinary backgrounds, some of 11:45
them still working. The campaign that followed demonstrates that one should never doubt a small group of thoughtful, committed people who want change. We've seen it in operation before. Recent examples are Hillsborough and Grenfell, but that should not 11:45
understate the courage, the sheer courage and determination, and usually powering it all, love and concern, that such an endeavour takes.

Using the long-established network provided by The 11:46
Society of Parent and Friends of Muckamore, our clients started to build their case. Some families, as noted, formed the group Action for Muckamore to highlight the issue for abuse. Together these groups sought information through Freedom of Information, subject 11:46
access requests, anything they could find to start to build their case. They began to engage with that the media to tell their stories to as many people as they could. They met with officials. They consulted

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

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

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

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

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

11:49

One of our clients has a loved one who has been a patient in Muckamore for 34 years, and deemed fit for discharge for the last 25 years!

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

more they fear that that is being compromised.

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

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

11:50

And that's their worry.

This Inquiry is not, of course, required to establish that it's wrong to abuse vulnerable patients in a hospital setting, and I'd like to think everybody would 11:50 accept that. Nor is it required to establish that people should not have to live their lives out in a hospital. Indeed we already know from the Terms of Reference what the Inquiry intends to investigate and be making recommendations on. Not the detail of those 11:50 recommendations, but the issues. However, these recommendations, important as they are, will effectively be rendered of little assistance in achieving the required change without the necessary funding. Many have advised, for years, what's 11:50 required. They know what good practice looks like, but we haven't got it yet, and there's a reason - my clients think. That ultimately would be the test of whether the State really does wish to end the

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

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

And here's the kicker:

"However, if the latest target for full resettlement is to be met, learning disability must be given a higher funding priority."

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

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

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

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

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

CHAIRMAN: Have they already been provided?

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

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

MS. ANYADIKE-DANES: Thank you, Chairman.

END OF SUBMISSION BY MS. ANYADIKE-DANES

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

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

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

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