MUCKAMORE ABBEY HOSPITAL PUBLIC INQUIRY
CLOSING SUBMISSIONS ON BEHALF OF CORE PARTICIPANTS
ACTION FOR MUCKAMORE
SOCIETY FOR PARENTS AND FRIENDS OF MUCKAMORE ABBEY HOSPITAL

PREAMBLE

"The body keeps the score"

1. This Inquiry was prompted by families who had been told their vulnerable loved ones had been abused whilst they were in Muckamore Abbey Hospital ("MAH") and under the responsibility of the Belfast Health and Social Care Trust ("BHSCT").

2. There are some loaded words in that statement. Firstly, vulnerability. They had mental health issues, learning disabilities, and many were non-verbal. Their vulnerability was clear and is indisputable. Secondly, loved. They were and are loved. The commitment, perseverance and attention of their families who in many cases organised their lives around visiting them to ensure they remained a part of the family and received the care they required is an abiding statement of that love. Thirdly, hospital. They were invariably admitted during a time of crisis in their lives to what was a specialist mental health and learning disability hospital whose task was to assess, diagnose, treat and care for them. Fourthly, trust. The families trusted; desperately wanting their loved ones to be helped and hoping and believing they had been admitted to a place which would do precisely that. Fifthly, abuse. They were abused; physically, sexually, psychologically, emotionally, neglected, misdiagnosed, inappropriately medicated and had their property interfered with.

3. So, in that single statement is all the hope, belief and expectation of the families, as well as the gross violation of trust and failure of responsibility by the authorities. In many cases it is that juxtaposition that so inflamed families and spurred them to take the action which has brought about this Inquiry.

4. But that is not the end of it. What needs to be fully and properly understood by all who had a hand in that breach and failure or who could and should have prevented it, is the

sheer extent of the harm that has been done. In a very real sense, the 'body keeps the score'. There are permanent scars on bodies that stand as a testament to the abuse inflicted. There are also other impacts of the trauma suffered, different scarring but just as enduring, which find expression in altered behaviour and changes in mental and emotional health. The families also have their own scars and are forever changed. To have willingly taken your loved one to be cared for in a specialist hospital at a time when despite your best efforts you could no longer keep them safe, to have voluntarily relinquished control with the imposition of a detention order, and then to be told they have been subjected to abuse whilst there, is a heavy burden for families to bear and some have been absolutely heartbroken by it.

5. But even that is not all. The families, and indeed the public, now know far more about what happened. The Review team for the 'A Way to Go' report published back in November 2018 watched just 20 minutes of CCTV[1].

6. The PSNI reviewed 300,000 hours as part of its Operation Turnstone[2]. Designated Adult Protection Officers also saw the same footage as the PSNI and subsequent CCTV footage that also captured abuse. A lot has been seen. For over a year the families have heard from those who had the responsibility to meet the needs of their loved ones and establish the structures, processes and systems that would ensure that they were properly cared for and protected. In listening to all that their overriding need was to know that whether in MAH (and some of them are still there with no clear date of discharge), in a community placement, or admitted to a hospital during a crisis, the needs of their loved ones would be properly met, they would be cared for and, above all, they would be safe. The evidence they have heard has not convinced them. The stark and distressing reality for many families is that the care provided to their loved ones continues to be deficient, and they continue to be at significant risk of abuse.

7. So, they seek from this Inquiry that most important of objectives in its Terms of Reference *"to ensure that such abuse does not occur again at MAH or any other institution providing similar services in Northern Ireland"*[3]. The reason for that is obvious. So many of them now have no choice but to entrust the care and well-being of their loved ones to some community placement. Whilst they remain hypervigilant, they are only too aware that cannot be sustained indefinitely and certainly not as they get older. Therefore, they need to know their loves ones will be looked after and safe when they can no longer intervene

to protect them. The public also needs to know that the vulnerable people in our society will be looked after and safe with a proper chance to have a good life.

INTRODUCTION

8. This is the submission on behalf of my 46 clients who are either affiliated to Action for Muckamore ("AFM") or members of the Society of Parents and Friends of Muckamore Abbey Hospital ("SPFMAH"). The Inquiry has referred to them as Core Participant Group 1 and Core Participant Group 2. Their combined experience of MAH spans nearly 75 years amounting to from within a year of MAH's existence to present day. That experience covers patients who without exception were abused in MAH, some of whom have died there and others that are still there waiting to be resettled into the community. Just about every issue this Inquiry has explored is one about which our clients and their loved ones have direct knowledge. They are the true experts on how MAH operated.

9. The core objectives of the Inquiry are set out in its Terms of Reference as being to:
   a. examine the issue of abuse of patients at MAH;
   b. determine why the abuse happened and the range of circumstances that allowed it to happen;
   c. ensure that such abuse does not occur again at MAH or any other institution providing similar services in Northern Ireland.

   To meet those objectives, the Inquiry has heard evidence in 4 broad phases: the Patient Experience phase, the Evidence Modules phase, the Staff phase and the Organisational Module phase.

10. We make these submissions on behalf of our clients in the light of the evidence heard during those phases. They set out their submissions in the same order as the Inquiry's core objectives. However, it is worth noting at the outset the general tenor of the evidence, which was markedly different as between those 4 phases of evidence:
    a. The Patient Experience phase recounted extensive and widespread abuse and neglect of extremely vulnerable individuals, with accountability and oversight mechanisms being completely inadequate and ineffective to identify or prevent that abuse.
    b. The Evidence Modules phase identified a system in which such abuse and misuse of power apparently should not have been possible.

c. During the Staff phase, many staff witnesses (with some notable and very telling exceptions) sought to portray a picture of MAH as a hospital at which nothing was particularly wrong, other than staffing issues.
d. The Organisational Module phase, in large part, heard accounts from organisations that clearly do not seem to acknowledge, accept or understand their responsibilities for the abuse that happened at MAH, with most seeking to shift blame or responsibility to others, especially to subordinates.

11. This last point is encapsulated most tellingly in the statement of Cathy Jack, CEO of the BHSCT, when she states that:

> *"It does not follow that because the Trust Board, or Executive Team, or Directorate level staff, or hospital level staff, did not know that patients were being abused in MAH in 2017, this therefore means there were not effective structures and processes in place capable of ensuring adequate oversight of MAH (or other similar facilities) by the Trust Board. Any governance system, no matter how well developed and comprehensive, relies on individuals doing the right thing. If, for whatever reason, this does not happen, then the governance system will fail. Each time an individual nurse, doctor, manager or colleague failed to further enquire or escalate a concern they should or did have (when they could and should have) then that also unfortunately means that the governance systems of the Belfast Trust failed as a consequence."*[4]

12. The message was that it was the fault of the individual nurse, doctor, manager, and ultimately the Director of service who failed to tell the Board, because as the CEO claimed: *"Matters then came to Trust Board on a planned issue basis, or on an exceptional basis when the relevant Director of a service believed that an issue required escalation."*[5] A similar approach has been adopted by the BHSCT throughout this Inquiry.

13. In many ways, for our clients, the most concerning thing going forward is the complete failure of management within the Trust, the RQIA and the Department, to acknowledge, accept or understand their responsibility for the abuse at MAH. Even where they did understand they had a responsibility; they seemed unable to recognise that the corollary of 'being responsible' was 'taking responsibility' when things go wrong.

14. Things most certainly did go wrong and yet it will have not escaped attention that no one at senior level has been sacked or resigned, whether at the BHSCT who had charge of MAH, the RQIA who was the regulatory body, the Department whose stated mission is *"to improve the health and social well-being of the people of Northern Ireland"*[6], or a Minister who has statutory responsibility for the direction and control of the Department[7]. This is despite it being widely reported that there were systemic failures and the system was dysfunctional[8]. Rather the 'hit' has almost exclusively been taken by front line staff. At the opening of this Inquiry, it was reported that 83 staff had been suspended with 7 sacked, and there had been 34 arrests with 8 charged[9]. Since then, there have been more arrests and 7 more prosecutions, but still, so far as has been reported, not anyone at senior level[10].[11]

15. In those circumstances the families have little hope that the BHSCT, RQIA or Department are capable, on their own, of implementing the necessary changes to prevent such abuse. Therefore, the Inquiry's recommendations and its actions into the future to follow up and monitor the proper implementation of its recommendations, become even more important. We have summarised in Appendix I the recommendations that our clients invite the Inquiry to make, and which are discussed in this closing.

CORE OBJECTIVE 1: EXAMINE THE ISSUE OF ABUSE OF PATIENTS AT MAH

GRAVITY OF THE ABUSE AT MAH

Introduction

16. Our clients consider the abuse at MAH was horrendous, prolonged and widespread throughout the hospital. They hope that all the evidence received has persuaded the Inquiry of the magnitude of abuse that occurred at MAH. An analysis of the evidence of the BHSCT and those involved in the oversight of its conduct in relation to MAH that we have drawn on has been provided to the Inquiry as Appendix II. Entirely separate and consistent accounts of abuse were repeated day after day during the Patient Experience phase. Cathy Jack CEO of BHSCT referred to *"some of the items of abuse that I witnessed [on CCTV footage] were deliberate acts of force or taunting to trigger vulnerable patients"* and makes the point that some of those instances occurred when the CCTV captured sufficient staffing[12]. Those who did watch CCTV footage have been changed by the experience[13].

17. On 2 November 2023 the Inquiry indicated its intention to conduct a holistic examination of the facts, adopting a suitably proportionate approach in order not to lose sight of the larger picture. It is not possible to detail every incident of abuse in this closing submission. There were simply too many. However, when the Inquiry makes its findings on the larger picture, it is important that the specific pain inflicted on the individual patients is not lost or passed over. Our clients therefore wish to remind the Inquiry – and the public who are watching – of the reality of abuse through a few specific instances across the categories of abuse set out in the Inquiry's terms of reference of what was inflicted upon their loved ones in MAH. The Inquiry will be aware of the very considerable evidence it has received from our clients and BHSCT staff across the full spectrum of abuse as defined in its Terms of Reference. There are other examples covered by Restriction Orders ("ROs")[14] and so cannot be described in an open session. However, they believe there is enough unrestricted material to bring home the nature of the abuse that has so deeply affected the lives of our clients and their loved ones, and which lies at the center of this Inquiry.

Admission and detention

18. The abuse perpetrated at MAH started with emotional abuse on admission. Many families gave similar and consistent evidence of being told they were not permitted to accompany their loved ones onto the ward or to visit or see their loved one for periods of weeks or months, ostensibly to allow their loved one to "settle in". This was incredibly distressing to patients and families. Such an approach caused trauma from which many have not recovered, and yet this issue did not even feature on the radar of staff or management at MAH or within the BHSCT or the Department. When questioned about this policy, Dr. Milliken the Consultant Psychiatrist and Clinical Director from 2005-2018, appeared oblivious to it[15] seemingly having absolutely no awareness of the trauma and harm it had caused.

19. By way of example of the prevailing attitude, P116's parents tried to visit him at Christmas but were turned away. It was the first Christmas they had not been together as a family. They went back to the car and cried their eyes out[16]. P124's mother told of how she was not allowed to settle her 11-year-old son into his bedroom and was forced to leave while he cried out for her to stay. This was very distressing[17]. P90's sister recalls how she and her mother were blocked by a nurse as they went to follow P90 into MAH.

They were not allowed to visit for 12 weeks. P90 had never been away from home before[18] and his mother was distraught. Such conduct exacerbated a time of crisis.

20. Moreover, there was a persistent failure to explain to families the purpose or basis of admission, provide a prognosis or treatment plan, explain their rights, or explore effective alternatives to admission. As a result, many families gave evidence that they expected their loved one to be admitted for just a few weeks of assessment and stabilisation only to find they would remain for years and in some cases, a lifetime. Despite this there was no admissions protocol until 2020[19].

21. Further, many "voluntary" admissions occurred simply because the family felt they had no option but to agree to admission and did so without understanding the distinction between voluntary and formal admission or having the distinction explained to them. Our clients' experience is that the significance of formal admission was rarely explained to families who subsequently felt as though they had lost all say over their loved ones' circumstances. Further, when it came to Mental Health Tribunals ("MHT"), they found the process was confusing and inaccessible to families, with a lack of proper advocates with the requisite expertise to provide effective representation. P119's mother told the Inquiry about going with her husband to an MHT with optimism, hoping to take P119 home for an overnight visit or even a short holiday. However, they were not admitted to the MHT hearing and their views were not heard. P119's mother left crying because her role as a mother had been taken away.[20]

Physical, sexual and emotional abuse[21]

22. Our clients gave evidence on the nature and extent of the abuse and neglect at MAH and in doing so they described the physical injuries sustained by their loved ones, the psychological and emotional abuse as well as the neglect of their care and basic needs. P124's mother told of bruising to P124's neck, which he showed her had happened when he was held down with a foot on his neck. He also told of staff making him crawl up a hill on his hands and knees[22]. P99's nephew recounted how P99 sustained a broken leg in 2012 with no credible explanation provided by staff[23]. P128's parents told the Inquiry of a time when P128's privates were bruised so badly that they turned black. Despite the police being called but nothing ever came of the investigation[24]. Other families recounted many, many, other incidents of a similarly distressing nature

23. Some staff did report abuse but did not see it result in appropriate action, such as Shelley Crawford an OT who reported a member of staff booting a patient up the backside and swearing at him only to be told *"OTs didn't understand the 'banter' at MAH"*[25].

24. Additionally, the evidence of our clients is that their loved ones were subjected to emotional abuse and threatened. P60 was teased about his much-loved father dying. He was also the victim of a sectarian attack, the impact of which prompted his admission to MAH. His sister describes how he was subjected to further sectarian abuse when in MAH which staff failed to stop: "*Another patient would go into [P60]'s room and use sectarian language and beat him up in his room. This patient would call [P60] a "fenian bastard". This was the language which was used when [P60] was beaten up at the age of 21 years. The patient said that he knew this because H512 [a member of staff] had told him. This language was a trigger for [P60]."*[26] This was not an isolated event, nor a hidden one as is clear from the evidence of James Wilson, a team leader for a bespoke living facility for MAH patients who also worked in MAH. He refers to another patient known to be triggered by paramilitary references being intentionally taunted by references to *"get the boys in to shoot his knees"* and that *"'the boys' were coming for him"*[27].

Lack of supervision and neglect[28]

25. There were patients who were assessed as requiring 1:1 or 2:1 supervision to keep them safe that were left alone, sometimes they were locked in a room for hours. This sometimes led to patients injuring themselves, choking or absconding. However, the presence of staff did not necessarily mean patients were receiving attention as they were ignored, with some being captured on CCTV apparently ignoring patients, focusing on their phones, chatting or refusing to help when it was clearly needed. P90's sister stated: *"On 25 February 2022 [P90] was left alone in a sensory room for two hours. In that time he managed to take the cord from his joggers and tied it around his arm to the point where he caused bruises and bleeding. There was also a period when he was down on the floor and banged his head repeatedly...From the CCTV it appeared that staff were in a different room talking, they were unable to observe [P90] from where they were and consequently [P90] was left unsupervised for about two hours, with staff only entering the room on a couple of occasions for about a minute."*[29]

26. It is also clear that personal hygiene needs were ignored. P124's mother, who states: "*P124 father and I were allowed into P124 room when he was in Erne. At times, we found*

that his bed had been made but there was a strong smell of urine. I checked the bed, and it was soaking. This had been left for him to get back into that evening. There were also times when we collected P124 he would have human faeces on him."[30] P90's sister states: *"[P90] is and has always been completely dependent upon carers for toileting and personal hygiene. I always hoped that this was being done correctly, but sometimes during visits I noticed faeces around [P90]'s fingernails, and tips of his fingers. I have had to ask staff to wash [P90]'s hands and cut his toenails."*[31]

27. The failure to address something as basic as toenails was widespread. P105's mother states: "*There was also a lack of proper attention to P105's feet and toenails, which got into a terrible state. At one stage P105's feet were covered in blisters and his heels were cracked. His toenails were frighteningly long, he had a fungal nail infection and at one point he had lost a toenail."*[32] See too P77's mother whose evidence is *"P77's toenails were so long that they grew over the top of his toe and curled at the back. It was not the shoes that were the problem, it was his toenails"*[33].

Medical neglect[34]

28. Our clients consider there was serious medical neglect at MAH. The Inquiry heard from P109's mother about how she suffered a severe adverse reaction to prescription medication that was persistently and wrongly diagnosed by staff as scabies. It was only through the rigorous efforts of P109's mother, which included taking her to the Accident and Emergency Department that it was eventually recognised to be an adverse reaction from her Lamotrigine medication which was then stopped[35]. P116's mother recounted a similar experience. He suffered a severe deterioration in his health from December 2016 with bleeding from his back passage and substantial weight loss. She was desperate for him to be seen by a doctor as she knew something was very wrong, but she was met with indifference and her complaints were ignored. It was not until August 2017, after she had telephoned the Royal Victoria Hospital ("RVH") and begged a secretary to get P116 an appointment, and had telephoned 999, that P116 was finally diagnosed as having tuberculosis[36]. The evidence of P118's mother provides a further example. In or around 2015 he was suffering from a chesty cold. She repeatedly asked staff to call a doctor and staff repeatedly failed to do so, with one nurse saying that P118 only needed a drink of water. It was only when she insisted that she was not leaving until a doctor was called that staff finally called the doctor. The doctor immediately had P118 admitted to Antrim Area Hospital where he was diagnosed with double pneumonia and spent four days in the ICU[37].

Dental neglect[38].

29. The evidence indicates that the dental care provided at MAH was appalling. P115's father states: "*When [P115] was first placed in Mallow [MAH] his teeth were inspected by a dentist who told me that his teeth were fine. In or around 2008/09, [P115] had to be referred to the Royal Dentistry Department. I asked for this referral but was told there was a three-year waiting list. I could tell that he was in pain as when he was eating he would lash out. We were seen by the dentist in RVH who said that [P115] needed several fillings and that he had two impacted wisdom teeth which were infected. I could not understand how this had been allowed to happen, as the dentist in MAH said there was nothing wrong with his teeth".*[39] See too P34's sister, who states: *"[P34]'s dental record in May 2023 details how he had to have two teeth extracted and had to receive seven new fillings. I remember how past and present, I would have said to staff about supporting [P34] in brushing his teeth. However, I felt they always used the excuse that he would not let them do it*"[40]. The evidence of P77's mother is in similar vein[41]. She recounted that in 2018 the dentist telephoned her and asked for permission to do some work on P77's teeth. The dentist advised that P77's teeth had not been cleaned in years. Before he went into MAH, she ensured that his teeth were brushed every day by doing it herself.

Nutrition[42]

30. Our clients' view is that staff simply did not seem to recognise the importance of proper nutrition and refused to listen to the input of families in relation to nutrition. There are numerous examples from our clients of their loved ones, either gaining or losing too much weigh in the absence of any proper meal plan. Others gave evidence of special requirements that were simply ignored. P77's mother provided a clear account of this problem. She bought flax seeds for her son because he had a constipation issue and asked for these to be sprinkled on P77's breakfast. On one occasion she brought a new packet of flax seeds only to be told by a member of staff to stop bringing them because they had twelve boxes in the kitchen. Staff had simply ignored her requests to use flax seeds in P77's breakfast as she had asked. P77's mother found this disheartening[43].

Inappropriate and over medication[44]

31. Our clients consider the approach to medication at Muckamore was terrible. Staff placed heavy and inappropriate reliance on medication to manage patients' behaviour because they did not have the knowledge, ability, willingness or time to use alternative therapies

such as Positive Behavioural Support. Worse, often it was the actions of staff that triggered the deterioration of patients' behaviour. Sometimes this was because staff lacked Learning Disability experience and did not know how to provide proper care, but the evidence also shows some staff intentionally sought to wind patients up for apparent amusement.[45] Moreover, the general lack of staff meant patients were deprived of activities to reduce the long periods of boredom when they had nothing to do and no one to interact with. There was also insufficient staff of the right mix and seniority to properly manage the wards, and some staff had inadequate training or experience to look after patients when they were at their most challenging. In our clients' view the effect of this was an increase in the use of Pro Re Nata ("PRN") medication, but as acknowledged by Dr Milliken Clinical Director, PRN usage was not subject to any trend analysis by MAH and that "*would have been helpful*"[46].

32. P118's mother stated: *"I felt that P118 was very sedated with the amount of medication that he had been prescribed. I felt that this was a means of managing him rather than treating him. This greatly annoys me because very often the staff do things to trigger P118's behaviour in the first place and then say that medication or seclusion are necessary to control behaviours which staff themselves have caused."*[47] See too P90's sister who stated "*It is my opinion that PRN was being used as a first response as opposed to the nurses using positive behaviour support … I was advised on the 8th August 2022 by a member of staff during a telephone conversation that lazy staff on the ward were using PRN medications as a first line management of [P90]'s agitation outbursts contrary to [P90]'s care plan."*[48]

33. The evidence of our clients is also that their loved ones were inappropriately medicated. Serious errors were made with medication, and administration was continued despite extensive side effects affecting the quality of their lives. They remained on medications for unduly long periods of time and records were not properly kept. MAH often remained unconvinced on the incidence of these until families were able to enlist the support of clinicians in other hospitals or in more specialist disciplines.

34. Whilst the Inquiry has had evidence from staff and the BHSCT that now supports much of what our clients have told the Inquiry, that was not the experience of our clients at the time the abuse took place, which is when they really needed it. They felt they were not listened to and were unsupported when they raised legitimate concerns about their loved

ones concerning over medicalising, receiving too much medication, inappropriate medication and a tendency to rush to prematurely use PRN rather than resorting to it as the last resort as should have been the case. All too often there was a lack of respect for the knowledge and experience they had about situations that triggered heightened behaviour and calming techniques that were effective. The pervading view seemed to be that clinicians and nurses knew better. The evidence has been that very often they did not.

Restraint and seclusion[49]

35. The evidence of our clients is that there was an over-reliance on the use of restrictive practices, such as restraint and seclusion, by staff at MAH and that these practices were regularly used as a form of punishment to instil fear in patients. They gave evidence of their loved ones being injured whilst being physically restrained. P77's aunt and P115's father both refer to their loved ones having broken and injured toes without any adequate explanation[50]. Whilst in relation to seclusion, P120's father stated: "*P120 told me about the seclusion room in MAH. P120 told me that on one occasion he was put in the corner of the seclusion room*, *slapped across the head and had cold water thrown on him. He said that it was a padded room and staff would call it the Naughty Corner'. I believe that it was used as punishment*. *P120 would be sat in a single chair and locked in the seclusion room. P120 cried to get out. The staff would say that P120 was being very bad. P120 was subjected to the seclusion room many times"*[51]. See too P124's mother who stated: "*I would ring PICU to get an update on P124 and quite regularly I would be told that P124 was in seclusion. I would have contacted the ward two or three times a day. I would feel upset each time because I knew how distressed P124 would have been due to being put in seclusion. P124 told me that he hated the seclusion room. He does not like to be on his own and this would have been a terrifying experience for him as he would not have understood why he kept being put into the room. It was not at all exceptional for staff to use seclusion…*"[52].

36. It is clear our clients' loved ones did not receive adequate care and support whilst in seclusion and that the conditions of the seclusion room did not ensure the safety, wellbeing and dignity of patients. P60's sister stated: "*P60 said that he was locked up, he was put in seclusion, he wasn't fed, he wasn't allowed out to go to the toilet, he wasn't given smoke breaks. You wouldn't treat an animal like that*"[53]. P109's mother provided a vivid description of the facility: "*There was a door beside the sensory tent which went*

down a dark corridor to the seclusion room. I was shocked by what I saw. The room was about three and a half foot wide and was more like a cupboard. There was only a large leather chair inside, which took up most of the room. The room was very dark. There was no window. It was a dismal, small, cold, dark room and not therapeutic in any way"[54].

Interference with finances and property[55]

37. So far as our clients are concerned, the evidence on patients' property was similarly scandalous. There were numerous, consistent accounts of staff failing to take adequate care of patients' money and property and being completely indifferent to patients' interest in having the benefit of their own belongings or even something as simple as being dressed in their own clothes. But it was far worse than that. The overwhelming weight of the evidence indicates that staff regularly misappropriated and stole patients' belongings. The consistency of the evidence of staff using patients' money to buy takeaway food for themselves[56] and of patients' property going missing - items such as toys, clothing (including presents of expensive clothes and shoes), aftershave, food, cigarettes, CDs and DVDs, CD players, phones, radios, games consoles and other electronic equipment, and of substantial amounts of money, as having gone missing with absolutely no explanation for the loss being provided to relatives – is striking. These items were often specifically chosen and bought for patients to be a reminder that they were cared for by their families. When families asked where these items had gone or complained about their loss, they were met with obfuscation and silence.

38. Brendan Ingram the Business Manager confirmed there was a policy on patients' finances at MAH before 2021, however Jan McGall, Senior Service Improvement Manager gave evidence that *"the day-to-day financial procedures weren't as tight as the policy suggested they could be and there was a lot down to timing. The financial management procedures appeared to be out of date and so staff were working on things that they had always done as opposed to what was useful for them. So, there was a need for a review…"*[57]

39. Staff kept some patient money in locked drawers on the ward. This was used by patients themselves if there was something they wanted to buy such as a snack, but it was also used by staff to purchase things on behalf of the patient. Miriam Somerville, Director of Learning Disability for hospital and community services explained; "*a patient could take money from that, spend it, go and buy his bar of chocolate and bring his change back*

and it would go back in the envelope but if a member of staff spent that money they had to provide receipts…and the receipts went in the envelope…the ward manager tallied the receipts with the amount of money in each envelope at the end of every week."[58] During Miriam Somerville's oral evidence the Panel queried the extent to which this constituted a fail-safe accounting system. Her response amounted to, *"the patient would come and ask either their named nurse or the ward manager for a certain amount of money…that would be noted in the envelope."*[59] That of course does not exclude the possibility of staff misappropriating a patient's money and simply noting on the envelope as having been given to the patient is not an adequate system for doing that.

40. Brona Shaw, Deputy Director of Nursing Quality, Safety and Patient Experience, confirmed that to her knowledge what the money kept in the drawers was spent on was not formally monitored and when asked if, prior to 2021, there was a policy around keeping money on the ward she responded, *"no, it was custom and practice, I think, I mean there's nothing in the old policy around that…I know that the RQIA equip just highlighted it as being a practice that should be stopped."*[60] She also commented that, "*things like that changed after the equip from RQIA to make it much more robust and that patients would have a much more, I suppose, agreed way of how their money would be spent, how it was recorded, who was responsible for that, who oversaw that, how frequently that was audited…"*[61]

41. The reality is that there was insufficient and inadequate oversight of patients' money. Money went missing. Families asked for receipts of how money was being spent but proper records were not kept. Families were also often asked for more money with no explanation as to how the previous money already provided had been spent. There were also concerns that patients' money was misappropriated or inappropriately spent by staff. MAH's accounts did not always match what families expected. Evidence has been provided to the Inquiry that staff members bought expensive aftershave, flameproof pyjamas costing £400, and other items using patients' money[62]. Shelley Crawford also gave evidence that *"Most service users were issued with 'comfort chairs' that they had paid for themselves…They should not have paid for this by themselves as if this was an assessed need the Trust would have to meet their needs and would have provided the appropriate chairs and maintenance of same…We were left with all of these chairs that were not fit for purpose that were paid for by the patients…I did report my concern about misappropriation of patient's finances to H717…"*[63]

42. Some families were pressured to put BHSCT/MAH in control of patients' finances, yet neither had a sufficiently robust system to take on that role. P60's sister, for example, stated: *"I had been [P60]'s financial controller from around 2014 after my father was no longer able to continue. I was asked countless times about the Trust taking on this role. I felt that I was being pressured and I declined as I was concerned there would be insufficient oversight of [P60]'s money and in my view that was necessary."*[64] Justification for that position is provided by Marie Heaney's evidence that *"In relation to finances the work needed was to re-educate and support staff teams of Adult Safeguarding policy and procedures and the relevant sections of the Mental Health Order (NI) 1986… despite the fact that Finance staff had recently conducted ward audits and training against the Belfast Trust financial procedures, the turnover of staff in finance and MAH management had failed to retain sufficient knowledge or robust systems about the requirements of Article 116. There was also a lack of clarity on whether the longer-term management of delayed discharge patients' finances was the responsibility of the placing Trust or the hospital…"*[65] In our clients' view it was all highly unsatisfactory.

Co-production – working with families and carers

43. The reports of serious failures in the care of vulnerable people consistently identify the need to listen to and work with families.[66] The research indicates that such working is to the considerable advantage of those being cared for. Yet in keeping with many other families of those in receipt of health and social care, there was a recurring theme throughout the evidence of patients and their families feeling that they were not listened to by staff and that their concerns and views were not respected. Our clients' experience is that staff lied and were dishonest to families as well as often being rude and aggressive. They had no trust in the staff at MAH and feared that if they made complaints their loved one would suffer or be punished in response. By way of example P60's sister stated: *"I really felt I could not turn to anyone, whether social worker, ward manager, service manager, RQIA, no one would listen."*[67]

44. The Chair specifically identified, co-production – working with families and carers, as one of the 'broad themes' emerging from the evidence[68]. It was pursued as a line of inquiry with staff witnesses including Mairead Mitchell who was the Head of Learning Disability Services Belfast Trust from 2016 – 2019. She was specifically asked to address in her Inquiry statement the procedures or processes that were in place to ensure co-

production between MAH staff and relatives of patients at MAH, to which she responded: *“In 2016 when I took up post, there was little evidence of co production between staff and relatives. There were meetings with relatives about care and treatment, but this was information giving by ward staff and not co production. The parents and friends’ group of the hospital did not appear to have a role or have regular meetings with management.”* [69] She goes on to set out how in 2017 she *“set out a plan for co production within the hospital setting which was already under way in the learning disability community services”*.

45. Notwithstanding the evidence of Mairead Mitchell, our clients do not consider there was any working system in place for co-production between the staff at MAH and the families or carers of patients. Rather their experience was that staff were dismissive and were slow to keep families updated about their loved ones including what treatment they were receiving, when they had to be admitted to hospital or when they were being relocated within MAH. Very often they lacked common compassion. P60 passed away as a patient in MAH and his sister’s evidence was: *"On the 07 January 2022, when [P60] choked, if my family had been contacted and spoken to [P60], he might still be here, but it is now too late...[P60] was on his own when he died and the fact [P60] never had his family with him will never ever leave me."* [70] and *"No one from MAH came to the wake or attended the funeral. No flowers were sent. I was in the height of grief and shock. MAH had been [P60]'s permanent home, yet no one came to offer their condolences."* [71]

46. Our clients’ experience is that they were provided with little to no information, documentation or paperwork explaining matters such as admission, detention, seclusion, medication or resettlement. No one took the time to explain these processes to families, many of whom were unfamiliar with them. By way of example P22’s sister stated: *“During P22's time at MAH, I received no adequate information from MAH staff as to P22's care, treatment or medication.”* [72] See too P120’s father who stated: *"I was never invited to meetings at MAH regarding P120 and his care. MAH were only in contact when they needed something."* [73]

Conclusion

47. This is only a tiny sample of the experiences of our clients. Nevertheless, the details described starkly demonstrates the sheer magnitude, duration, and institutional nature of the abuse that went on at MAH.

48. The Inquiry has heard evidence from senior personnel within the BHSCT and the Department that the abuse and neglect was secret and concealed and therefore almost impossible to detect notwithstanding effective systems of governance that were in place. Our clients ask the Inquiry to categorically reject that notion. It is clear from their evidence and that of other witnesses, including BHSCT staff, that it is plainly not the case[74]. Much of what went on in MAH was done in plain sight. That is what has been so difficult for families to comprehend. Furthermore, abuse still happens in MAH and in other facilities in Northern Ireland caring for vulnerable people with mental health issues and learning disabilities. That is the evidence of not just our clients but also of others[75], who are incredulous that abuse can continue at MAH despite it having been under a spotlight for the 7 years since the scandal broke and under investigation by this Inquiry for 3 years.

49. It brings shame on our society that such abuse, perpetrated against some of the most vulnerable individuals in society, can still occur in present day.

TIMEFRAME OF THE ABUSE

1949 to present day[76]

50. It was only through the viewing of CCTV footage that the scandal of abuse at MAH broke. The BHSCT, the Department, and independent reviewers[77] all agree on the importance of CCTV in revealing the abuse at MAH. Yet at the outset BHSCT had to be required to watch all the available CCTV not just a small fraction[78]. Those in post at the time have been clear in their evidence to the Inquiry. Peter McNaney the Chairman of the Board said it *"was only the "game changing" impact of CCTV that allowed the true picture of abuse on at least some MAH wards, and at least in 2017, to be revealed and demonstrate that more effective action needed to be taken"*[79]. Whilst Cathy Jack the Chief Executive Officer said, *"I think the sea change in picking up the issues in Muckamore was the CCTV"*[80]. See too Sean Holland the Chief Social Worker Officer said *"the initial incident that was raised in 2017, had it not been for CCTV, could very easily have just been a case of just one person's word against the other"*[81]. Our clients agree with that view, as that almost insurmountable "*he said, she said"* approach was one they had been confronted with for years, but for them the issue for the Inquiry is more: Why? Given the governance processes and structures that had been put in place, why did it fall to the chance viewing of CCTV in September 2017[82] for such abuse to be discovered?

51. The CCTV was installed in 2015 in Cranfield wards 1 and 2, the Psychiatric Intensive Care Unit ("PICU") and Six Mile ward. It was commissioned and handed over to the BHSCT by the contractor on 9 July 2015. BHSCT entered an initial contract with Radio Contact for the maintenance and upkeep of the CCTV system for the period 1 December 2015 to 30 November 2020[83]. The system was periodically tested by Radio Contract and appears to have been mistakenly left operational when it was tested in February 2017 prior to the planned launch date of 11 September 2017[84], an incredible 2 years after it was ready for use.

52. Countless staff and BHSCT witnesses came to the Inquiry and expressed their apparent shock and surprise at the abuse uncovered by the CCTV. Since horrendous and widespread abuse was only uncovered by CCTV, and given that staff and management have, for the most part, taken the position that they were entirely unaware of the abuse or its scale, it is not possible to determine with clarity or certainty how bad the situation was prior to the viewing of the CCTV in 2017.

53. A variety of points have been made in evidence to the Inquiry that appear to try and portray the abuse discovered in 2017 as resulting from factors largely outside the control of either MAH or the BHSCT. Most prominent was the ongoing staffing crisis. But this had been apparent since at least 2011 with staffing levels being referred to in 2012 by the Associate Director of Nursing for MAH as *"dangerously low"*[85], which not only left some wards with *"unsafe staffing",* but meant there were insufficient staff with the appropriate kind of training and experience to care for a patient population dominated by those with serious learning disabilities. Also referenced was the renewed drive to resettle patients into the community and change the focus of MAH from a facility catering to long-stay patients to simply a hospital. But resettlement had been a feature of MAH since the Bamford Review of 2007[86], so there was nothing new in that. Whilst, it may have gained renewed focus with the 2012 publication of the Transforming Your Care review that urged resettlement be completed by 2015[87], that was not the first challenging resettlement target. The Programme for Government for 2008 to 2022, included the goal of *"Ensuring that, by 2013, anyone with a mental health problem or learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital"*[88].

54. Our clients urge the Inquiry to reject any suggestion that however difficult those pressures may have been to manage, and they were well known, that they in anyway justify the abuse that was inflicted on their loved ones in MAH or any of the other vulnerable patients there.

55. The Inquiry will need to look elsewhere for the underlying reasons. It has heard evidence that the abuse discovered at MAH however shocking should not have been surprising to those in senior positions charged with the responsibility to ensure there were adequate governance processes, systems and structures. The avoidance and detection of abuse is what should have been built into their very design. This is captured by the evidence of Sean Holland Chief Social Worker Officer: *"I think there is a general point about the risks associated with running facilities of this type. Those risks are very well known … that institutional care of vulnerable people carries with it inherent risks that providers should be aware… It is a known risk that when you care for vulnerable people in large group living settings that you need to be aware of, and I think that just should be part of the ongoing business."*[89] Winterbourne View in England is frequently cited as an example, with its pertinent finding that: "*We have been here before. There is nothing new about the institutional abuse of adults with learning disabilities and autism"*[90]. But we need not step out of Northern Ireland. We have our own institutions of shame, evidenced by the Historical Institutional Abuse Inquiry and Mother and Baby Homes and more recently, Ralph Close, Cherry Tree House, Dunmurry Manor Home, and Bradley Manor Care Home.

56. So, whilst MAH may have been 'a place apart' as it has been frequently described, in terms of a place where there was a real risk of abuse, it certainly was not 'a place unique'. Our clients hope that the Inquiry will have that context in mind when it considers what should have been done to protect their vulnerable loved ones and the extent to which those in senior positions *"at the apex"* are entitled to wring their hands, apologise but claim they could not have known because the perfectly adequate system of governance they had installed did not alert them to it[91].

57. The evidence strongly and distressingly suggests that the abuse uncovered through CCTV in 2017 was merely the tip of the iceberg, and that abuse of extremely vulnerable patients has always been a reality of life at MAH. The combined experience of our clients with MAH spans almost its entire existence, with the first being admitted a year after it

opened and some still in MAH now. Their accounts make clear that there has always been abuse at MAH, even if there was no CCTV to confirm it[92].

58. The Inquiry has also heard of abuse dating back to the 1960s and 1970s that came to light in 2005 and gave rise to the PSNI conducting a comprehensive review of the files, which revealed 24 incidents that were potential offences.[93] Furthermore, the Inquiry has received extensive evidence on the abuse that occurred on Ennis Ward in November 2012, and how MAH formed the view that the issues were "*isolated to practices within Ennis ward, rather than hospital-wide institutional abuse*"[94], with the result that a more extensive investigation did not take place which might have established a culture of abuse earlier. In our clients' view abuse was certainly there and should also have been factored into the 'risk' to be managed by the governance systems and structures.

Present day into the future

59. The scandal of abuse at MAH only broke because of the efforts of P96's father, as acknowledged by the Minister in 2020, his *"determination was central in exposing the truth about Muckamore. It shouldn't have been left to him to do this but we should all be very grateful that he did"*[95]. Up to that point, the BHSCT simply had no handle on the abuse. Indeed P96's father faced substantial opposition from within the BHSCT in his efforts to obtain the CCTV[96]. Our clients consider that the reality is that, had it not been for the efforts of P96's father in 2017, the scandal may never have come to light, and the situation at MAH could have continued without scrutiny. They find that gravely concerning.

60. Moreover, notwithstanding that the abuse came to light in 2017, the clear and consistent evidence of our clients is that abuse continues on an ongoing basis. So, for example, although P77's mother and aunt gave evidence of the abuse suffered by their loved one in MAH, which has been acknowledged, he continues to suffer abuse. Furthermore, they have numerous examples of neglect concerning feeding, failure to provide any activities and to follow procedures in terms of safeguarding concerns and privacy. In addition, abuse continues in the community placements to which patients are discharged from MAH as, for example, P90's sister and brother are only too aware. In their experience, staff in the community lack the necessary qualifications and experience in learning disability. Also, staff who were involved in MAH continue to work in the community, with

no effective mechanism for families to identify this or to seek assurances that their loved ones will not be placed in their care.

61. Whilst it is hoped that these issues, and others, will be addressed in the forthcoming 'resettlement evidence sessions', it is worth noting them as part of the context from which to assess the evidence of staff and officials as to their intentions in relation to the care of vulnerable people with mental health issues or learning disabilities. In all the circumstances, this Inquiry has the grave responsibility of *"[e]nsuring such abuse does not occur again".* This is not merely an aspiration. Abuse and neglect continue to happen. It is therefore essential that the Inquiry identifies practical and effective ways to prevent abuse and neglect as a matter of urgency.

CORE OBJECTIVE 2: DETERMINE WHY THE ABUSE HAPPENED AND THE RANGE OF CIRCUMSTANCES THAT ALLOWED IT TO HAPPEN

Introduction

62. The Inquiry's primary timeframe is 2 December 1999 to 14 June 2021. Across that period the Inquiry has heard evidence of gross failures, deficiencies and missed opportunities with the HSC system in general and within Learning Disability Services in particular. Our clients ask the Inquiry to make a clear finding that the failures were institutional, systemic and substantial.

63. Our clients consider it is necessary not only to identify the causes of abuse, but also to hold those responsible to account. In their view, the lack of accountability in the past is one of the fundamental reasons why serious and widespread abuse was able to continue for so long. So far as our clients are concerned frontline staff perpetrated abuse without accountability. Management of the hospital displayed an utter disregard for patients and families without accountability. Leadership of Learning Disability Services, the BHSCT, the Board, and the Department, completely abdicated their responsibilities without accountability. Those tasked with holding health and social care organisations to account similarly failed in their roles without accountability.

64. From our clients' perspective there has been no accountability with regards to the dysfunctional implementation of CCTV. There has been no accountability with respect to incompetent staff planning. There has been no accountability with regards to dysfunctional safeguarding investigations or complaints processes. There has been no

accountability of Healthcare Assistants who were unregulated and were therefore able to move on to other community jobs even if there had been problems with their work in MAH. There has been limited accountability for the failure of senior personnel to engage with the Leadership and Governance Review. There has been no accountability for the RQIA's casual disregard of family complaints. There has been no accountability for the ineffective representation by advocacy services within MAH and before Mental Health Review Tribunals. Many of those responsible did not even come to the Inquiry, retiring or getting new jobs and leaving it to newly appointed personnel to come to the Inquiry and account for actions or decisions of which they had no personal knowledge or experience. In this way, individuals who bore responsibility escaped direct scrutiny of their conduct. So far as our clients are concerned, hat cannot be tolerated, as the lack of accountability, and the complete impunity of those working within the system, even when they manifestly failed to discharge their responsibilities, is a core cause of the abuse.

65. Our clients have a legal right to have individuals held accountable for their specific roles in the abuse at MAH. Their loved ones were subjected to serious and prolonged abuse to the extent that their rights pursuant to Articles 2 and 3 ECHR are engaged. Consequently, the state has a mandatory duty to conduct an effective investigation into the abuse to ensure accountability of those responsible. The Inquiry has not sought to discharge the full extent of the state's Articles 2 and 3 obligations. For the reasons given in the Chair's statement of 2 November 2023, the Inquiry adopted a holistic approach to ensure the Inquiry could complete its work within a reasonable timeframe[97]. That was a matter for the Inquiry, but it means that the Articles 2 and 3 investigative obligations have not yet been discharged through this inquiry and that is an issue of fundamental importance.

66. That obligation has also not been discharged by the police investigations. The current Operation Turnstone police investigation is limited in temporal scope to the CCTV recovered for March 2017 to November 2017, which relates to only a fraction of the abuse. In any event, as the jurisprudence shows, an effective investigation goes well beyond facilitating a prosecution[98]. Furthermore, it has not been discharged by the various investigations by the BHSCT, which as the Inquiry has heard were ineffectual and cannot on any analysis be regarded as adequate, independent or conducted with the necessary elements of public scrutiny and participation of Next-of-Kin. Inquests will discharge the obligation in some circumstances, but this mechanism does not apply to

circumstances in which individuals were subjected to life threatening treatment short of death or for those who were subjected to treatment contrary to Article 3 ECHR.

67. The issue of accountability is not simply historic. It is intrinsic to preventing such conduct in the future, which is a key aim of Inquiry's Terms of Reference. Thus, there is a need for a further investigation as the failure to hold those responsible to account means that the system of providing learning disability services within the community can be populated by some of the staff, management and leadership who are themselves responsible for abuse at MAH and who have never been properly held to account or experienced any form of disciplinary or other sanction for their role. Our clients gave accounts of personnel from MAH who turn up as staff at their loved one's community placement, re-traumatising them. This is entirely inappropriate and in their view is only possible because there has been no comprehensive mechanism to secure accountability of all involved.

68. Accordingly, circumstances, our clients seek a finding from the Inquiry that the state's investigative obligations under Articles 2 and 3 ECHR have not been discharged by the investigations to date, and that there is a need for a further investigation into the individual allegations of mistreatment to ensure that those responsible can be identified and, if possible, brought to account. Our clients suggest that such an investigative mechanism could operate in tandem with an appropriate remedial scheme. With that core point in mind, we now provide an overview of key events and our submissions on the circumstances that caused and allowed the abuse to occur.

OVERVIEW OF KEY EVENTS

69. We have provided to the Inquiry a chronology of relevant events as Appendix III. The following is a brief overview of key matters within the Terms of Reference, which illustrate the failure to learn and the common theme of the failure to take proper responsibility for the discharge of functions. Our clients regard this as fundamental to understanding how the abuse was able to happen.

Bamford and Equal Lives in September 2005

70. In 2005, the Equal Lives report[99] (as part of the 'Bamford Review') set out a vision for developing services for those with learning disabilities for the following 15 to 20 years. The foreword to the report stated:

"The Equal Lives Review has concluded that progress needs to be accelerated on establishing a new service model, which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else.

The success of implementing the Equal Lives recommendations depends on the contribution of many stakeholders, but most of all Government, who must give a lead on implementing the process of change. We fully recognise the resource implications and urge Government, in particular the Department of Health, Social Services and Public Safety, to begin the necessary process of reform and modernisation of these services immediately."[100]

71. The direction of travel was clear. It is equally clear that we are not there yet and for entirely foreseeable reasons. The Inquiry heard from the Professor Sir Michael McBride Chief Medical Officer that *"…I regret that I wasn't more thoughtful in terms of the risks that that transition from one service, in-patient service model into working to provide a service in the community...we did not have an overarching strategy for that other than a commitment…"*[101] This was a rare public acknowledgement. In general, though, there is a reluctance to be open with those with mental health issues, learning disabilities, their families and the public in general, about the problems in realising the Bamford vision and how those problems will be fixed. Rather there is simply the continued public restatement of the commitment to the Bamford vision, which our clients consider an insult to their intelligence as they know the reality on the ground. For them, such restatements and repackaged commitments ring hollow.

72. The Inquiry has heard evidence on the implementation of the Bamford vision of: Action Plans (with the misleading assessments of the extent of progress); Service Frameworks; monitoring reports; implementation bodies; oversight bodies, and the Learning Disability Service Model that is intended to chart a better future and deliver on the commitment to care in the community. That model is still in draft, still to be consulted on, and still to be costed[102]. In short, we do not yet have the Model, and it is unclear when we will or what it will ultimately look like when we do[103]. So, the harsh reality is that 20 years on from the

Equal Lives report, 8 years on from the scandal of abuse at MAH, and more than a year after the closure of MAH was announced, central government and the Department have failed to implement the Bamford vision. In truth, they are nowhere near implementing the Bamford vision.

73. The resettlement programme is not yet complete; and even if it was complete, the key point is that the state of community-based services is dire. For many of those who have been resettled, their circumstances are a far cry from Bamford's vision of a model based on *"integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else."*[104]

74. For many of our clients, the resettlement programme has only served to shift the problems from MAH into the community. Furthermore, abuse in MAH continues, and their experience is that resettlement of itself is not a solution to abuse. As to the reasons for this, our clients agree with Professor Roy McClelland's assessment in 2019 that the abuse at MAH was not just *"bad apples in a barrel"* and *"instead, there is something wrong with the barrel"* and there was a *"need to look at the system"* as *"it's more than just failures within the trust – it strikes me that we may be looking at the tip of the iceberg"*[105]. The system is failing people with learning disabilities. Whilst there are a number of reasons for this, 2 factors are key; the lack of funding and the lack of a workforce strategy, both of which were identified as long ago as the Department's 1995 Review 'Care in the Community'[106] and are specifically addressed by Bamford[107]. This warrants further analysis. Starting first with the December 2005 Review of Eastern Health and Social Services Board ("EHSSB") and North and West Health and Social Services Trust ("NWHSST") into alleged sexual abuse of patients at MAH review[108].

EHSSB and NWHSST Review in December 2005

75. This review was within a couple of months of Equal Lives and was prompted by the discovery of allegations of sexual abuse in the 1970s by a former patient in MAH. He had been admitted in 1971 as a child and alleged sexual assault by patients and staff, which had been reported to medical and nursing staff, but the abuse had continued[109]. These issues apparently came to light following the settlement of civil proceedings in December 2005. As a result, the EHSSB and the NWHSST conducted a case-note review, which

not only confirmed that reports of sexual abuse had been made but identified other similar incidents involving other patients.

76. The EHSSB and NWHSST also commissioned a review of current practice and care in MAH. That review was carried out by Miriam Somerville the Director of North and West Belfast Health and Social Care Trust ("NWBHSCT"), with an objective being to *"assure the Trust and EHSSB of the robustness of vulnerable adult procedures"* [110]. The review was an internal, entirely paper-based exercise, so there were no interviews of patients, families or staff. Some of our clients had loved ones in MAH at the time and were unaware of the review or its circumstances.[111] The approach adopted was unfortunate, especially as it covers issues such as the 'complaints procedure', 'patient discussion groups', 'independent advocacy', 'management of visitors' and 'communication processes', all of which directly involve patients and their families. Furthermore, it refers to the 'Society of Patients and Friends' without interviewing or seeking comments from our clients P107's brother or P90's sister who were the chairperson and secretary of SPFMAH.

77. So far as our clients are concerned, the approach is not surprising as they are well-used to their knowledge and experience not being used to inform matters concerning the care and safety of their loved ones, despite every study referred to the Inquiry emphasising the importance of doing precisely that[112]. They regard the review of limited value in meeting its terms of reference and cannot see how it could provide the assurance on the appropriateness and robustness of the procedures that the NWBHSST and EHSSB were legitimately seeking. It seems not to have led to confidence in the Department. The following year Andrew McCormick the Permanent Secretary wrote to all HSCT Chief Executives reminding them that whilst the incidents of sexual abuse dated back some years, *"it remains essential that we have in place appropriate and proportionate procedures to prevent such abuse"*, and seeking formal assurance that *"all appropriate policies and procedures to prevent and where they occur, detect and manage allegations and incidents of abuse, are in place and are being consistently and robustly applied… the Department needs to be assured that services are safe"*.[113]

Reduction of Trusts in 2007 and Reform of HSC in 2009

78. The Review of Public Administration was launched in 2002 to review the existing arrangements for the accountability, administration and delivery of public services in

Northern Ireland and bring forward options for reform[114]. It was conducted over a 3-year period and the implementation of the reform it proposed for health and social care had 2 distinct phases; the reduction in the number of the Trusts in 2007; and the reform of health and social care organisations in 2009.

79. The first phase involved the reduction in 2007 of the number of Health and Social Services Trusts from 18 to 6[115], which led to the creation of the BHSCT as by far the largest HSCT in Northern Ireland having been formed from the amalgamation of 6 legacy Trusts. This was significant for MAH, which went from being under the control of the NWBHSST, a community trust in which it was the only residential facility, to BHSCT that not only had responsibility for MAH as one of several acute in-patient units dealing with mental health and learning disabilities but also several major teaching and training hospitals[116]. It would seem from the evidence the Inquiry has heard, including from the Permanent Secretary Andrew McCormick, that insufficient consideration was given to this: "*we didn't spend a lot of time thinking about this because the momentum was so strong. You know, I probably regret not taking what was said to me slightly more seriously and saying, it would have meant going to a minister and saying you see that plan we've got, we need to hit the pause button. That would not have been a welcome intervention.*"[117]

80. The evidence to the Inquiry demonstrates that following the creation of the BHSCT, the focus on Learning Disability Services, both in the community and in MAH, was substantially reduced[118]. The relevance of this is that after 2007, instead of increasing the focus on learning disability services to realise Bamford's vision, the BHSCT lost its focus on learning disability services and treated them with lesser importance. Whilst much has been made in evidence to the Inquiry of the size of the BHSCT and its impact on governance[119], our clients categorically reject any suggestion that the size of the BHSCT was the root cause of this problem – large organisations successfully function in many contexts. The problem was that the leadership of the organisation focused on acute services and failed to maintain rigorous and effective oversight with respect to the learning disability services for which they were equally responsible.

81. The second phase in 2009 involved the reform of the health and social care system pursuant to the Health and Social Care (Reform) Act (Northern Ireland) 2009. This:

a. transferred the functions of the Mental Health Commission (MHC) to the Regulation and Quality Improvement Authority (RQIA);
b. replaced the 4 Boards with a single regional Health and Social Care Board (HSCB);
c. established a Public Health Agency (PHA);
d. established the Patient and Client Council (PCC).

82. The reforms did not secure any positive outcome for MAH. These bodies were completely ineffective in terms of preventing abuse there. The RQIA's regulatory activities completely failed. The HSCB had responsibilities with respect to 'performance management', 'service and quality improvement', 'delegated statutory functions', 'complaints', 'serious adverse incidents', 'legacy adverse incidents', 'early alerts' and 'safety and quality alerts', but each of these processes failed to pick up on or identify the abuse at MAH. The PCC was the advocacy body on behalf of patients, but it had no specific focus on MAH between 2009 and 2019 and many families had never heard of it. The PHA was so ineffective that on the first day of hearings on 'professional organisation' when its Chief Executive Aidan Dawson came to give evidence[120], he did not even seem to appreciate that the PHA had any significant role in relation to Learning Disability Services. This is even though the PHA's full title under the legislation is "The Regional Agency for Public Health and Social Well-being".

Ennis Adult Safeguarding Report, August 2013

83. On 7 November 2012 a member of staff from Bohill Care Home, a private sector community placement provider, reported that a staff nurse, a healthcare support worker, and a student nurse at MAH had physically abused 4 patients in Ennis Ward. In response to these allegations there was a police investigation, a safeguarding investigation and subsequently a disciplinary investigation. The staff were referred to the Independent Safeguarding Authority and the Nursing and Midwifery Council was notified of the precautionary suspension of the registered nurse involved. An Early Alert was issued to the Department of Health and the Chief Nursing Officer[121]. Only 2 individuals were prosecuted (with one being acquitted and the other being found guilty but subsequently having their conviction overturned on appeal). At this stage there was already a staffing crisis in MAH but given the utmost seriousness with which the matter was treated, the BHSCT introduced 24-hour monitoring of staff on a supernumerary basis on Ennis Ward as a response.

84. However, the real issue with the Ennis Ward incident was the lack of proper oversight exercised by the BHSCT (or the Department, which had been notified by an Early Alert and should have been exercising oversight). This is demonstrated by just a few points.

85. First, there was already a staffing crisis at MAH in 2012 before the Bohill staff reported abuse on Ennis Ward. So, the directorate-level response of introducing 24-hour monitoring of staff on a supernumerary basis had the entirely foreseeable effect of imposing a substantial additional financial and staff burden and introducing additional risk into what was already a crisis. Although, the BHSCT Board was made aware of the Ennis allegations, they simply took the approach that, because the matter was receiving attention, there was nothing further for them to do. It appears that the matter was not even considered by the Assurance Committee, which is supposed to provide independent scrutiny of what is going on through the non-executive directors [122]. This is a failure of leadership. It was incumbent on the BHSCT Board, and the Assurance Committee, to maintain effective oversight of the response, given that the allegations of abuse were serious, the behaviour took place openly in front of external staff, and the senior management's response had introduced significant additional risk into what was already a staffing crisis.

86. Second, the HSCB repeatedly recommended to the BHSCT that the matter be treated as a Serious Adverse Incident ("SAI"), but the BHSCT declined[123]. It is recognised that a previous iteration of the SAI policy was in place and appreciated that there is subjectivity around determining whether an SAI should be conducted. Nevertheless, that the HSCB considered the incident should be treated as an SAI, and the fact that the matter had not been treated as an SAI, cried out for proper scrutiny and oversight from the leadership of the Trust. That oversight did not happen and the evidence of the Department to the Inquiry is not only was that warranted but that it *"may have resulted in the notification of a SAI and subsequent review which could have opened up learning for the Trust and wider HSC system."*[124]

87. Third, Aine Morrison the Designated Adult Protection Office ("DAPO") in charge of the safeguarding investigation and John Veitch the Co-Director for Children and Adult Learning Disability Services, had a difference in view on the issue of institutional abuse. Mr. Veitch took the view that there was no concern about institutional abuse. Ms. Morrison took the view that it was not possible to reach a conclusion on whether there

had been institutional abuse. This difference of views was never resolved. It is clearly of itself a serious matter that should have received scrutiny and consideration from a higher level within the BHSCT. That did not happen. Whilst it is possible to lay blame at directorate level for failure to escalate, our clients consider that the greater blame lies with the leadership within the BHSCT for its failure to maintain effective oversight. The circumstances of the Ennis reports required greater scrutiny. If that had happened, leadership in the BHSCT would have become aware of the difference in view and further scrutiny and consideration would have been required.

88. Fourth, the safeguarding report and the disciplinary report came to inconsistent conclusions. That is a startling position. It cries out for further examination. It is acknowledged that the inconsistency in the conclusions stems in part from the fact that there were 2 processes and by the time of the disciplinary investigation the Bohill staff did not engage with the investigation team. However, that is itself a matter which required further consideration at a senior level, because it demonstrated that the processes on which the BHSCT leadership was relying were not operating in a coherent way. Again, it is possible to lay blame at the directorate level for the failure to escalate this matter. However, our clients contend that the greater failure is the failure by the BHSCT Board and Assurance Committee to exercise effective leadership and oversight over a matter which manifestly required their involvement.

89. Our clients consider that Ennis was a missed opportunity because, had the BHSCT leadership become involved, the nature of the staffing crisis at the hospital should have become apparent at a senior level, and should then have received the attention it required. This did not happen. It is submitted that it did not happen because the leadership in the Trust were failing to properly take responsibility for the discharge of their functions; and because the Trust Board were far more concerned with issues in acute services rather than in learning disability services.

A Way to Go, 2018

90. Dr Margaret Flynn chaired the independent team which carried out a level 3 Serious Adverse Incident Review in 2018. This was one of a series of assurance measures established by the BHSCT and notified to the Department in November 2017 in response to the abuse discovered in 2017[125]. The terms of reference for the review focus on the effectiveness of various arrangements for safeguarding at MAH primarily during the

period 2012-2017. The resulting report was provided in November 2018[126] after which Dr Flynn attended a BHSCT Board meeting on 5 September 2019 to report on her meetings with families following the review and to update the Board on changes[127].

91. Our clients question the methodology for what was being presented as a truly independent review. As appears from Dr Flynn's evidence to the Inquiry[128], it seems the BHSCT selected the terms of reference without any ability for the review team to provide input. There was no agreement on whether the report would be made public or at least provided to the patients and families directly involved, with the review team proceeding *"naively"* on an assumption of publication. The time frame of 2012 to 2017 was chosen by the BHSCT without any initial explanation of its significance. Furthermore, and again without initial explanation, the reporting of adult safeguarding incidents in PICU and Six Mile ward focused narrowly on the period August 2017 to October 2017, the significance of which had to be inferred as the review progressed. The 69 safeguarding files to be reviewed were selected by the BHSCT without any explanation of the method by which they had been singled out. Whilst the review team was informed of CCTV footage, it was not provided as part of the material for them to consider, rather it was left to them to request sight of it as a matter of curiosity to assess its *"quality"*. Ultimately, a mere 20 minutes was watched[129], and it is unclear what they were told to inform their choice, or why such a limited period was viewed given the primary objective was to examine safeguarding practices.

92. Ultimately, the Report, 'A Way to Go', produced by the Review team ten months later identified multiple serious problems at the MAH. However, it failed to hold individuals responsible for failings in their duty, particularly in relation to that part of its Terms of Reference that required it to *"assess the leadership within Muckamore Abbey Hospital"*[130]. It made just 2 recommendations, both of which essentially sought a renewed commitment to the implementation of Bamford. Given the available material, our clients are disappointed that more was not done by the Review to further the aim of safeguarding, especially as the Review team was aware of the earlier reports of abuse at MAH in 2005, 2012 and of obviously 2017.

93. Some 6 years on from those 2 recommendations, it is clear the Way to Go report represents a further missed opportunity for the BHSCT and the Department. It is another example in a long line of examples of recognition of what is required to happen but a

failure on the part of the BHSCT and the Department to take the necessary steps to bring about effective change.

Review of Leadership and Governance at MAH, July 2020

94. Another opportunity to address governance shortcomings in MAH and by association BHSCT, was provided when the Department, the HSCB and the PHA commissioned an independent review to *"examine critically"* the effectiveness of governance[131]. The essence of the terms of reference was to "*Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to the quality, safety and user experience"*. This was to take in a series of issues including 'strategic leadership across the Trust', 'clinical leadership and accountability'[132], which seems to have been prompted by the belief that the Way to Go report *"did not cover leadership and management issues to the degree that they wished to have it covered"*[133]. In other words, it did not entirely succeed in providing the intended assurance to the Department.

95. The timeframe of the Review was 2012 to 2017, the same as for Way to Go, and it examined the key milestones of Ennis, CCTV, and the complaint of P96's father. The report was highly critical, highlighting that: MAH was allowed to operate *"under the radar of the Trust"*; the *"leadership at MAH was dysfunctional"*; there was *"a lack of interest and curiosity at Trust Board level"*; *"staff felt a loyalty to one another rather than to the Trust"*; and matters were not appropriately *"escalated to the Executive Team or Trust Board as a means of finding solutions"*[134]. However, of huge significance was its conclusion that *"the Trust had adequate governance and leadership arrangements in place but that these were not appropriately implemented at various levels within the organisation."* [135] This deflected attention from the system of governance itself and focussed instead on the role of the individuals down the chain of command. Not surprisingly, Cathy Jack CEO of BHSCT relied on the Review's finding to support her assertion that *"the structures and processes in place in the Belfast Trust were sufficient"*[136] and the issue was individuals not "*doing the right thing"*[137]. So, whilst the need for curiosity at all levels was acknowledged, nonetheless the Board's position was that the hierarchical governance system, which relied on an escalation of concerns up to the Executive Team and Board, had been largely exonerated by the Review.

96. In our clients' view the conclusion reached by the Review was incorrect and unsupported by the evidence. This was exposed when David Bingham, a member of the Review team, gave evidence to the Inquiry. He was forced to concede[138] that having already recognised that medical leadership was not involved in clinical governance, it was simply incorrect to say BHSCT *"had appropriate governance in place"*. Furthermore, *"the Board [should], and particularly the non-execs, have been proactively asking for assurance information rather than waiting for serious incidents to be reported through SAIs job of the non-executives"*, i.e*. "not to passively wait for information to come to them [but] to actively go out and seek assurance about things"*.

97. The upshot is the Review was yet another missed opportunity to alert the BHSCT to the deficiencies that permitted significant patient abuse. Worse yet, it allowed a misplaced confidence in the essential elements of the system to continue, which necessarily avoided a focus on what really needed to be addressed to ensure the safety and interests of patients would be properly safeguarded. Our clients find it difficult to understand how the Review that took nearly 2½ years to produce, could have been undermined so quickly. It leaves them with little confidence in the ability of the BHSCT to examine and correct its failings, given the apparent need to have this Inquiry to identify them.

SUBMISSIONS ON THE CIRCUMSTANCES WHICH CAUSED AND ALLOWED THE ABUSE TO HAPPEN

98. Our clients have identified 9 main factors that caused and allowed the abuse to happen. They are not mutually exclusive but are cumulative and overlapping. Each is exacerbated, and the risk of abuse made more likely, by the failure to hold all those responsible to account.

(i) Vulnerability

99. The abuse at MAH was perpetrated against people who were particularly vulnerable. They relied on others for their care and to keep them safe. They were often unable to communicate when that care fell below the required standard, or they were being abused. Even when they could do so, their efforts (and those of their families) to report or draw attention to it, were often ignored, went unnoticed, or were not believed. It is difficult to imagine a more vulnerable set of people at risk of harm.

100. At times witnesses have suggested the answer to the abuse is simply to complete the resettlement programme. Our clients disagree and consider it is essential the Inquiry rejects this analysis as overly simplistic, given that their loved ones will continue to be vulnerable wherever they are placed. The resettlement programme was not designed to prevent abuse. Indeed, as Professor McClelland made clear, the prevention of abuse was not a driver behind the Equal Lives recommendations[139]. So, while completion of the resettlement programme is necessary, the solution is not merely resettlement to a community setting. It is essential that this fundamental point on vulnerability and its implications is properly appreciated by all stakeholders who should not be relying on completion of the resettlement programme as the means of ensuring the safety of our clients' loved ones into the future. In some respects, they may well be more vulnerable in their community placements, because their placements will be smaller and dispersed throughout Northern Ireland without the level of scrutiny that is currently trained on MAH.

101. The essential point is that abuse is inextricably linked with vulnerability. If abuse is to be prevented in future, it must be appreciated by everyone involved that, risk goes beyond institutional settings and is present in any setting in which vulnerable individuals are accommodated – small or large, public or private. Proper adult safeguarding of vulnerable people requires more than a change of setting. This also means that the abuse is unlikely to have only occurred in MAH, and there is the high probability, as indicated by Sean Holland Chief Social Worker Officer, that such abuse is **currently** going on in other places where vulnerable individuals are housed, including in community placements, particularly if there is an absence of strong oversight and no CCTV[140]. Thus, although MAH is to be closed, it remains the case that identifying the various causes of abuse, and effective ways to prevent them from happening again, is an essential and urgent factor in the successful placement of our clients' loved ones, and others, in the community.

(ii) Culture within MAH

102. Our clients consider that the culture within MAH was bad. There was a toxic environment, with poor practices partly caused by staff families working together, resistance to outside scrutiny and to those seeking to make improvements, disrespect and mistreatment of families, and ultimately patients were abused, often openly, on multiple wards, with prolonged impunity for the staff concerned.

(iii) Failure of Leadership throughout the System

103. Our clients consider that many of the failures in relation to MAH are linked by a common theme: the failure to take proper responsibility for the discharge of functions. This failure can be seen at every level, in every organisation, and across the system. Far too often the Inquiry heard evidence from senior personnel who sought to shift blame for failings to their subordinates, and to claim that it was their subordinates' fault for not telling them when things went wrong. This position was taken by management at MAH, by leadership of the BHSCT, and by leadership within the Department. They all seemed to consider it was an appropriate exercise of governance to wait to be told by someone else[141]. Indeed, that is how the system was set up. As Gordon Smyth, Non-Executive Director and Chair of the Audit Committee within Belfast Trust from 2016 to date, stated in his oral evidence: *"As non-executives it wasn't for us to go down and see what was happening at the coal face. We were relying on our directors coming back to us and saying this is A, B, C and what we were seeing from the reports we were getting back was that we were making progress."*[142]

104. The Department and BHSCT leadership time and time again sought to emphasise that the basis of the system was delegated responsibility and accountability. We have already referred to the statement of Cathy Jack. The Inquiry heard similar exhortations from Department and BHSCT witnesses such as Brendan Whittle, Professor Sir Michael McBride, Peter McNaney, and Martin Dillon[143]. This repeated emphasis laid bare the problem at the heart of the Department and the BHSCT. No one doubts that the BHSCT and Department operate through a system of delegated power. But it is a fundamental principle in any system of delegation, that responsibility remains with the delegator. This is not, and should not be, a hollow or meaningless responsibility. It means that, when the delegator's subordinates fail to properly discharge that responsibility, the delegator is ultimately responsible and must bear full accountability for the consequences. Because, although subordinates must account to the delegator; the delegator must account to everyone else for their failure to ensure that their responsibility was carried out effectively.

105. In short, leadership requires proper oversight. This means it needs people who, although delegating power, retain responsibility over the exercise of that power, and act accordingly. That requires rigorous efforts to ensure the power is in fact being used properly, to ensure that outcomes are being achieved, and to ensure that the information

used to make those assessments is of good quality. This is because the delegator understands that, if things go wrong – irrespective of whether they have delegated their power – they will be both responsible and accountable. However, that does not seem to be the approach adopted for MAH.

106. At times the Inquiry heard the failure to exercise proper oversight described as *"a lack of interest and curiosity"*[144]. Whilst our clients do consider that those in senior positions were professionally incurious to an astonishing degree, particularly given the risks associated with an in-patient facility such as MAH, in their view, the problems at MAH were not merely caused by a lack of "professional curiosity". It was not simply a case of professionals doing the bare minimum with insufficient or inadequate inquiry. The problem was greater than that. The problem was bad governance. It was a case of professionals completely abdicating their oversight functions to subordinates and then seeking to blame subordinates when things went wrong.

107. Fundamentally, this was a failure by leadership and management to recognise that, although delegating power, they continued to be responsible and continued to have a **duty** to exercise rigorous and effective oversight over matters for which they remain professionally responsible and accountable. Moreover, it was a failure by leadership and management to recognise that, if they do not exercise proper oversight, they are both responsible and accountable for any harm that is caused as a result. This point applies throughout the system; but it applies with greatest force to the leadership of the system. If the leadership of the system exercises rigorous and effective oversight, then there will be very little room for wholesale failure of the system. Conversely, if the leadership fails to exercise rigorous and effective oversight, it is far more likely that everyone else in the system will follow suit. Our clients consider that is precisely what happened in relation to MAH.

108. There have, at times, been suggestions that the issue was the size of the BHSCT, that it was simply too big following the re-organisation of Health and Social Care[145]. Our clients do not accept that is an adequate excuse. Large organisations can and do function effectively and successfully under the right leadership and with the right approach. However, if the leadership of a large organisation is not effective, then systemic problems will remain unaddressed, and the scale of failure will be all the greater. That is what happened in relation to MAH. It is clear to our clients that the leadership within BHSCT

were simply unprepared for and incapable of management of a large organisation, they failed to maintain effective leadership or oversight of Learning Disability Services, and they must take responsibility for the harm caused as a result.

109. It is also possible to recognise the other factors at play, such as the individual responsibility of frontline staff, toxic culture on particular wards and within some teams, staff families and friends working together, existing staffing issues. These problems were serious and should not be underestimated. However, the reality is that a leadership team that proactively seeks and obtains necessary assurances on matters under their responsibility, via multiple sources, based on high quality evidence, will address such issues; whereas an organisation that simply relies on upward reporting, from single sources, with poor quality evidence, will inevitably fail.

(iv) Inadequate Funding of the System

110. The funding was inadequate. There was inadequate funding for staff at MAH, there was inadequate funding of the resettlement programme, there was inadequate funding of or investment in community services, and there was inadequate funding of Learning Disability Services generally. Miriam Somerville summed up the problem when she said: *"It was difficult to encourage both Trusts and Boards to believe that investment in community services would actually result in the changes in the hospital that everybody wanted and that had been on the cards since the mid '90s. Because I wasn't part of that commissioning group, I don't know why that was the case, but there was just very limited investment in community services. Yes, frustrating is absolutely the word."*[146]

111. But the fault does not only lie with Trusts and Boards. The Department must also bear some responsibility. The Bamford Equal Lives Report made clear that substantial additional funding would be required to realise the Equal Lives vision. The evidence demonstrates that, despite repeated commitments to implement Bamford, including at the highest level and within the Executive's Programme for Government, nowhere near the requisite level of funding was made available. In the circumstances, it was galling for our clients when Sean Holland came to the Inquiry and highlighted *"a reluctance on the part of some patients and their families to relocate"* as a barrier to meeting resettlement targets[147], along with other factors which seek to lay blame on everyone but the Department. The reality is that the additional resources for resettlement for 2008-2011 to which Sean Holland refers[148] and the substantially reduced additional resources for 2011-2015 to which he does not refer, provided nowhere near the level of resources that Equal

Lives said would be required to achieve the resettlement programme. In the circumstances, it is unsurprising that families were reluctant to agree with various proposed resettlements because many community placements were simply not fit for purpose and that continues to be the case. That in turn contributed to delayed discharge and other problems in MAH.

112. It was particularly galling for our clients to hear Sean Holland try to paint the Department's progression of the resettlement programme as some form of success in claiming the majority of MAH patients had been resettled[149]. The fact that the majority of have now been resettled, decades outside the timeframes set by Bamford, and for some after several failed placements, is not a mark of success. The reality for our clients is that the dire state of community services rendered many of the community placements unsuitable for their loved ones. Thus, resettlement served only to shift the problems from MAH into the community.

113. The Department, and the relevant Health Ministers, are responsible for this state of affairs because they sought to implement Bamford without providing the level of funding to develop the placements and community infrastructure that Equal Lives said would be required, and without being transparent about the fact that it was failing to provide the necessary funding. It is a matter of significant concern to our clients that the Department fails to transparently recognise or acknowledge this as the central factor in the failure of resettlement.

114. Moreover, there appeared to be little or no engagement with or recognition of the fact that the implementation of Bamford would require double funding for a period so as to run the hospital at the same time as developing community services to the requisite standard to enable resettlement to be successful. As a result, our clients consider that the proliferation of groups, teams, and monitoring structures directed at practical implementation of the resettlement programme was largely a waste of time and money. Since while there may have been much difficulty and complexity in managing specific individual resettlements of patients, the overall problem was simple: there had been inadequate funding of community services to enable safe and effective resettlement of all patients and that is what had to be grappled with.

115. The resources poured into managing the process of resettlement over a prolonged period and which gave a false impression of action, may have been better directed at simply improving community services as Bamford had indicated.

(v) Inadequate Expertise within the System

116. Learning Disability Services were staffed, managed and led by too many people who lacked sufficient qualifications or experience in Learning Disability. The Inquiry heard much evidence of the lack of staff with any Learning Disability experience, and the approach of using staff with Mental Health experience instead. Moreover, for those staff who did have experience in Learning Disability, there was nevertheless a lack of adequate knowledge. Moira Mannion, the Co-Director for Nursing, Education and Leaming and then the Deputy Director of Nursing and Workforce Education, Regulation and Information Technology, gave evidence[150] of a directive to locate education within Northern Ireland rather than in, for example, Bradford or Kent. However, the evidence indicates that the local courses did not provide the same focus on essential matters such as Positive Behavioural Support. This had a detrimental impact on the culture of treatment within Learning Disability services.

117. Our clients give the following non-exhaustive examples that are illustrative of the extent to which the various levels of leadership and management lacked adequate knowledge of or experience in Learning Disability and were, therefore, reliant on subordinates:
    a. Esther Rafferty, Service Manager, MAH (January 2012 – 2018); Associate Director of Nursing, MAH (April 2018 – August 2018) who had a mental health nursing background with experience *"in mental health as distinct from learning disability"*[151]
    b. Mairead Mitchell, Senior Manager Service Improvement and Modernisation in Adult Social and Primary Care, BHSCT (2007 – 2016); Head of Learning Disability Services, BHSCT (2016 – 2019), a registered nurse, midwife and health visitor but appears to have had no qualification in Learning Disability[152]
    c. John Veitch, Co-Director for Children's and Adult's Learning Disability Services, BHSCT (January 2011 – September 2016)[153]
    d. Moira Mannion, Co-Director of Nursing Education and Learning (2007-2018); Deputy Director of Nursing and Workforce Education, Regulation and Information Technology, BHSCT (2018-October 2019) who was a registered mental health nurse but whose curriculum vitae discloses no Learning Disability qualifications[154]

e. Cecil Worthington, Director of Social Work/Children's Community Services, BHSCT (September 2012 – September 2017); Interim Director of Adult Social and Primary Care Services (August 2016 – August 2017) was a qualified social worker but appears to have had no qualification in Learning Disability[155]
f. Catherine McNicholl, Director of Adult Social and Primary Care Services, BHSCT (September 2012 – July 2016), who had no experience, qualification or other grounding in learning disability[156]

And at BHSCT Board level:

g. Brenda Creaney, Executive Director of Nursing and User Experience, BHSCT (January 2010 – July 2024), who had no experience of Mental Health or Learning Disability when she became Director of Nursing, claiming her *"professional background is adult nursing, children's nursing and neonatal intensive care nursing."*[157]
h. Gordon Smyth, non-Executive Director, BHSCT (April 2016 – date) and Chair of the Assurance Committee who was a retired banker with no *"experience or exposure to Learning Disability services"*[158]
i. Bernie Owens, Director, BHSCT (2014 to date and with responsibility for MAH from 2019 – 2020); Deputy Chief Executive (2021 to date) a registered nurse who had no qualifications or any *"experience in relation to Learning Disability or dealing with patients with particularly complex needs."*[159]
j. Peter McNaney, Chair of BHSCT (2014 – 2023), a solicitor by profession who made it clear that he *"didn't have any experience in learning disability"*[160].
k. Martin Dillon, interim Chief Executive, BHSCT (June 2014 – December 2014); Chief Executive, BHSCT (February 2017 – February 2020), an accountant by profession and a finance officer who appears to have had no experience in Learning Disability[161]
l. Professor Sir Michael McBride, Chief Medical Officer, NI (September 2006 to date); acting Chief Executive, BHSCT (December 2014 – February 2017) – *"I have no general or specialist medical training in mental health or learning disability"*[162]

118. Our clients have been clear all along that the safe and effective care of their loved ones with learning disabilities, especially those with complex behaviours and conditions, requires individuals who are trained, qualified and experienced in the field of learning disability. This means people with the right knowledge and the right skills to provide the right type of care and the requisite level of care. It also requires leadership and management with sufficient knowledge of the particular context of Learning Disability to know what assurances to look for, what information is required to make those assurances

meaningful, and to recognise when things are going wrong. Ultimately this did not happen at MAH and could not happen because of the severe lack of personnel with knowledge and experience of Learning Disability. Our clients found the lack of leadership and management with learning disability experience, particularly within MAH, to be extremely frustrating. They want the Inquiry to secure the proper accountability of those who allowed the abuse their loved ones suffered to come about.

(vi) Inadequate Staffing

119. There was inadequate staff planning, there were insufficient numbers of staff, and there were inadequate working terms and conditions were not such as to bring about any real change. Bamford identified that a workforce strategy would be required and made recommendations accordingly, but the recommendations were not properly implemented, and a wrong turn was taken on foot of the Deloitte Report, 'Workforce Planning in Mental Health and Learning Disability: Implementation of Bamford Review Recommendations, obtained by the Department in 2009'[163]. As a result, reliance was placed on the release of staff from MAH as patients were resettled. Ultimately that did not happen.

120. As a result, there was a staffing crisis in MAH from 2010. The staffing crisis was apparent to everyone who conducted even a basic analysis of the position (using Telford which did not provide an objective assessment of the true staffing requirements in a Learning Disability context). However, the evidence of Moira Manion was that even when that happened, and staffing was increased, the increase would then be followed by a round of cuts and reduction in numbers to contribute to the required 3% saving[164].

121. This is in a context where the staffing crisis was even greater than appreciated because management had inadequate knowledge of Learning Disability to realise that additional staffing was required than would be the case for other services. Moreover, the crisis was made worse by the response to Ennis (that required additional staff to supervise care on the wards over a prolonged period); and was made worse again by the abuse scandal in 2017 and the suspensions that necessarily followed. This in turn led to even greater reliance on bank and agency staff who lacked qualifications or experience in Learning Disability.

122. Additionally, whilst the BHSCT oversaw a reduction in the number of nurses and healthcare assistants, in apparent furtherance of the vision of care in community

placements rather than long stay hospitals, there was no joined up thinking about securing a consequent increase in a social care workforce with learning disabilities experience and expertise[165]. This is clear from the evidence of Moira Mannion who acknowledged *"at that time the approach by our social work colleagues and the approach by nursing were a little discordant with one another, and there was a need for joined up thinking and joined training opportunities."*[166] To add to the incoherence of this system from 2016, and despite the serious staff crisis, there was an underspend on staffing from 2016. That there should be an underspend in circumstances where there is an acknowledged massive staffing crisis simply beggars belief and eloquently demonstrates the dysfunctionality of the system.

123. Thus, the problem was not simply that the staffing system lacked sufficient resilience to respond in times of crisis. The problem was that, due to the complete lack of coherent staff planning, the staffing system was not fit for purpose even before the crises hit, and the crises led to a further spiral. Thus, when some witnesses suggested that the staffing crisis was no different from the general staffing problems seen across the health service, this was entirely wrong, and missed the serious, additional and avoidable staffing problems which were present in MAH.

124. As if all of that was not bad enough, this took place in a context where leadership and management seemed not to appreciate the difficulties and the complexity of the job that staff in Learning Disability Services have. This point is summed up by Professor McConkey when he stated:

> *"…in the group homes, you were very often employing what you might call care assistants. Now, these were talented people in terms of their personal qualities and often when the NVQ system was up and running, they were getting a lot of extra training and well able to provide good-quality care in those settings.* ***And they are still, to a large degree, an exploited workforce with, if you like, minimum pay often being offered to them because the Commissioners have often been trying to drive down the costs. But if you look at value for money in terms of, well, what quality of life are you buying for the money you're spending on staff, that changes the agenda considerably."***[167]

125. So far as our clients are concerned, what is required is a resilient workforce, trained and qualified in Learning Disability, who are provided with working terms and conditions (in terms of both remuneration and support) that reflect the difficulty and complexity of the job they are required to do, and the responsibility which is placed on them when they do it. Minimum pay and bad working conditions are not acceptable. The system will only change once it is recognised that a properly skilled, properly paid workforce is essential. There is currently nothing even close to that[168].

(vii) Failure to treat Learning Disability Services with the same value as Acute Services

126. There was a failure to treat Learning Disability Services with the same value as Acute Services. This was not concealed. It was blatant.

127. Cecil Worthington's statement to the Inquiry is that: *"It often felt like there was a more immediate focus on acute services at the Trust Board itself."*[169] He put further context on that in his oral evidence: *"I think it was around 2014, there were huge pressures on the Trust to comply with the various standards and targets in accident and emergency, for example…while there was a patient waiting for a bed the Royal Victoria, they passed away and it was major media news. It was such an event that – and it's the only time, I had a 40 year career but it's the only time in my career that the Health Minister came to the Executive Team because of the event and made it very clear what he expected in terms of meeting targets. And I mean, it was no coincidence that in that year the Chief Executive and Medical Director both went and sought other jobs because there was a lot of pressure on the Executive Team at that time. That heightened the focus on 12 hour breaches, four hour targets. So I can well understand why my colleagues were so focused on acute events."*[170] Unfortunately, the Inquiry does not have any evidence from a Minister on these assertions which seek to explain what led to the focus of the BHSCT on acute services at the expense of social care. The impact of policy decisions is clearly an important issue as was recognised by the Permanent Secretaries in their evidence to the Inquiry[171].

128. John Veitch gave evidence to the Inquiry that *"when I came into post I saw Learning Disability as an underdeveloped service. When I first went round some of the wards in Muckamore I was pretty shocked by dormitory living for patients, which I didn't think it was appropriate. So I think there was – and, you know, people in LD who had worked*

there all their lives said that it, it was almost a Cinderella service. Part of my job as Co-Director was to advocate for that, to kick up a fuss, to support my staff in making representations to improve that. But we were where we were…"[172]

129. H51's statement to the Inquiry states: *"During the majority of my career as a nurse I have worked with patients with learning disabilities. I have no doubt that this part of the health service has been what I would call the "Cinderella" of the health system. It is often under-resourced and understaffed."*[173] John McCart gave similar evidence.[174]

130. Richard Pengelly gave the following evidence in response to questioning: *"Q. I am just wondering from your leadership perspective looking at a field such as Learning Disability Services, I mean would you accept that within the context of such a large structure it can tend to be overshadowed by other services? A. I couldn't push back against that, I think it's a fair assertion."*[175]

131. The problem is also starkly illustrated by Shelley Crawford's (Occupational Therapist's) evidence that, prior to her arrival at the hospital came to the hospital in December 2012, there had been no Occupational Therapists at MAH for approximately 30 years. This is not because Occupational Therapists were not needed. On the contrary, Shelley Crawford's evidence demonstrates that they were sorely needed. It is submitted that the only explanation for the failure to make this basic provision available is that people with learning disabilities were treated with less value than patients without learning disabilities.

132. There has been a suggestion at times that one way of dealing with this problem may be for a separate Trust to be created, dedicated to Mental Health and Learning Disability. There is a possibility that this would bring about a greater focus on Learning Disability and avoid the problem of Learning Disability being overshadowed by Acute Services[176]. However, there is also a risk that this would simply shift the problem to a higher level, so that the overshadowing of Learning Disability Services and Acute Services would simply happen at Departmental level when funding decisions are being made.

133. Our clients contend that the inherent problem in this context does not lie in the nature of the structures. Most structures can be made to function by the right people with the right attitude. The inherent problem lies in the fact that there is a systemic culture and attitude of treating Learning Disability Services with lesser value than Acute Services. That

problem will only be solved by recognising that that is wrong, and by changing attitudes throughout the system.

(viii) Failure of Accountability Mechanisms

The Regulation and Quality Improvement Authority

134. The RQIA was the regulator. It had oversight of quality under the Health and Personal Social Services (Quality, Improvement and Regulations) (NI) Order 2003 and oversight of care and treatment under the Mental Health (NI) Order 1986. However, it completely failed in its task of regulation. That is clear from the extensive evidence during the Patient Experience phase of patient abuse and neglect. Nor was this abuse and neglect undetectable. On the contrary, failings such as inadequate dental care, inadequate podiatry care, absence of basic hygiene, unlawful detention, theft of personal items, urine-soaked mattresses, and many other consistent features of the patient experience evidence, should have been picked up by the RQIA. But very often they were not.

135. Our clients contend that failure was caused by a range of factors, including rushed and superficial inspections, unannounced inspections never being truly unannounced, inadequate engagement with or respect for families, inadequate attention to the particular context of Learning Disability Services, inadequate advocacy services that could have engaged with RQIA on behalf of families, inadequate use of CCTV, and an inexplicable bias in favour of the organisations they were charged to inspect.

136. When the regulator approaches its duties in this way, it is largely irrelevant whether they have high quality policies, procedures and inspection mechanisms. Processes and procedures cannot be a substitute for subjecting the service provider to the proper level of suspicion and scrutiny.

137. The above factors must be addressed if the RQIA is to improve its effectiveness as a regulator. Ultimately, however, it is clear the RQIA is too small in scale, size and funding to be relied on as an effective oversight mechanism on its own. The Inquiry heard evidence of improvements that the RQIA is seeking to make, including a shift from a solely “wards-based” inspection to “systems-based” inspections and efforts towards a new IT system that should allow for better analysis of information. Such improvements are obviously essential. However, the reality is that RQIA can only be successful if it subjects the service providers to a strong level of suspicion and scrutiny, and if it is

combined with other strong oversight mechanisms, including the use of CCTV, a skilled advocacy service, and fundamentally a strong and effective system of governance and assurance within the Trusts themselves.

Advocacy Groups

138. Advocacy Groups were unacceptably weak and ineffective. This can be demonstrated by a simple consideration of the Flynn Report, which noted that the extent of the advocacy assistance (at the same time as egregious abuse was being perpetrated at MAH, staffing levels were dangerously low, and the resettlement process was dysfunctional) was seeking a shelter for smokers. This is demonstrative of the gap between what was provided and what was required.

139. Our clients contend that the vulnerabilities of people with learning disabilities mean that a strong, effective Advocacy Service is essential to keep their loved ones safe. This is no less important in respect of Learning Disability Services in the community. If anything, it is more important, because individuals and their families will be more disparate and less able to identify systemic issues on their own, and therefore there may be less scrutiny on each individual placement. It is also necessary that people can have access to strong advocacy assistance that is able to identify systemic issues arising in their caseload and advocate accordingly.

(ix) Inadequate respect for Families, their Knowledge and Experience

140. The system did not respect the input of families. It did not seem to value the knowledge and experience they had not just in dealing with their loved ones, but in the practicalities of dealing with those with Learning Disabilities. This attitude applied even to those with professional training such as P90's sister. Consequently, there was a failure to reckon with the value families might bring to a system that was lacking in Learning Disability training and experience and yet had to provide safe and effective care to patients with extremely challenging behaviour.

141. This was a problem throughout the system. It manifested in numerous ways: in the failure to provide any proper explanation of the admissions process; the failure to explain the purpose of admission; the policy that families were not allowed to see their loved ones for weeks and months after admission; the failure to properly deal with complaints from families; a scepticism over the significance of family input; the casual disregard for

families at multi-disciplinary team meetings; the failure of RQIA to listen to families; and in the failure of the leadership to engage with families. Families gave consistent evidence of their mistreatment, of a patronising approach by professionals, and of a frustrating and distressing lack of communication. Such an approach is entirely unacceptable. It emphatically requires a culture shift within the system.

CORE OBJECTIVE 3: ENSURE THAT SUCH ABUSE DOES NOT OCCUR AGAIN AT MAH OR ANY OTHER INSTITUTION PROVIDING SIMILAR SERVICES IN NORTHERN IRELAND

142. For our clients, the importance of this objective cannot be overstated. The recommendations which the Inquiry makes, and the actions that it identifies are required to follow up and monitor implementation of those recommendations, will be vital to securing the safety and well-being of their loved ones into the future.

143. In that regard, it will be no use to our clients if the Inquiry makes recommendations which are accepted in principle but never properly implemented. That has happened too many times before. Nor will it be any use if recommendations are made if the requisite funding is not made available. That is a matter of particular concern, because the reality is that the requisite level of funding to secure an adequate community-based system has never been made available.

144. In summary, for our clients, what is required can be identified with relative simplicity: a properly funded, properly staffed, community-based learning disability service; with rigorous, up-to-date governance, assurance and oversight systems (to include the use of CCTV); leadership and management that has knowledge (or ready access to knowledge) of learning disability services; an effective regulator; and effective advocacy services. Our clients consider that the recommendations the Inquiry makes should be focused on securing that outcome and securing it as soon as possible. In summary our clients identify the following 13 key findings and recommendations they consider should be made by the Inquiry, some of which will be informed by the forthcoming session on resettlement and available community services.

(i) Funding and (ii) the Need for Information on Learning Disability Services

145. The requisite level of funding must be determined according to the needs of people with learning disabilities. That requires proper data on the numbers of people with learning disabilities and data on their level of need. It is only once those needs are known that

what is required to discharge them in a community-based system can be identified and the requisite level of funding determined.

146. The Equal Lives report included the following: "*In conducting the Equal Lives Review*[177] *we have highlighted difficulties in accessing accurate information on the numbers, needs and services available to people with a learning disability and on the amounts of funding being invested in services for them. In order to accurately evaluate the impact of the implementation of the Equal Lives Review recommendations and to plan more effectively* ***there is a need to establish better systems for tracking people and funding and assessing outcomes. In particular new systems should provide information on services and supports needed by individuals as well as those they are receiving.*** *These records should allow for better integration of information that to date is held separately in education, health, social ser vices or housing systems, taking account of the Data Protection Act. Experiences in England, Scotland and Republic of Ireland would help to inform the development of an appropriate data set."*

147. Our clients contend that the requirements of those with learning disabilities has never been comprehensively identified or met. There continues to be a need set out in the Equal Lives report to establish better systems for tracking people as well as for funding and assessing outcomes. Without accurate information, it has been and will continue to be impossible to coherently fund or provide for an effective community-based system of Learning Disability Services. Our clients therefore seek a finding that the current information system is inadequate, and a recommendation on the need to implement a coherent system for gathering and maintaining accurate information on the size of the population in need of learning disability services, the services and supports they require, and on what is currently available. This matter should be further informed by the forthcoming session on resettlement and available community services.

(iii) Staffing

148. The system must be staffed with people with adequate skills, qualifications and training in Learning Disability. That will require an increase in the current workforce. It will require strategic workforce planning. It will also require updated training courses that provide up to date learning and which consciously and rigorously strive to embed the necessary culture in students and trainees from the outset, not just in those courses relevant to learning disability, but in health and social care training generally to address the problem

of a “hierarchy” of service areas. It will also require working conditions that recognise the difficulty and importance of working in Learning Disability Services and the high level of skill and knowledge required. Again, this will be further informed by the forthcoming session on resettlement and available community services.

(iv) Governance, Assurance and Oversight

149. This Inquiry has shown that the voluminous body of policies and procedures, including those on performance management, complaints, SAIs, SQAs, etc., was not merely ineffective, but may in fact have been part of the problem. This is because it provided a false appearance of assurance and a false belief throughout the leadership and management that the system in which they were engaged provided effective governance and assurance. It meant that leadership and management throughout the Health and Social Care system completely failed to understand what was required or where they were going wrong.

150. Our clients consider the focus must be on the difficult task of changing the culture of reliance on long and complex policies and procedures at the expense of effective outcomes. As a starting point, they ask the Inquiry to make a clear finding, with a view to embedding a clear message within the Health and Social Care system, that a system of governance and assurance based upon upward reporting, through single sources, relying on low quality evidence, simply will not work.

151. Proper governance and assurance require leadership and management to proactively seek assurance, on all matters under their responsibility including the absence of poor care and the presence of good care and should require high quality evidence with multiple lines of assurance. Moreover, when things go wrong due to leadership and management failing to properly discharge that function, it is essential that leadership and management are properly held accountable and responsible.

(v) Involvement of families

152. Our clients seek findings on the need for the:
    a. establishment of the entitlement of families to be properly informed and involved in decisions concerning the placement, care and well-being of their loved ones,
    b. development of a mechanism to give effect to that entitlement,

c. establishment of a ready means for families to enforce their entitlement to be informed and involved.

And recommendations to that effect.

(vi) CCTV

153. The use of CCTV is inherently linked to the issue of governance, assurance and oversight because it provides objective evidence on the standard of care provided. It was a source of anger and frustration to our clients that, on the one hand, witnesses from the BHSCT and Department consistently came and told the Inquiry of the indispensable role of CCTV in uncovering the abuse scandal at MAH, while, on the other hand, many families faced strong and substantial opposition (including from BHSCT, other Trusts and the private service providers they engage), in their attempts to have CCTV installed in the community placements of their loved ones. It was also a source of frustration to our clients that in those circumstances the courts have failed to appreciate the central importance of CCTV in uncovering the abuse perpetrated at MAH, and thus, in their view, failed to attach adequate weight to the value of CCTV. Our clients consider it is **essential** that the Inquiry makes a strong recommendation on the need for CCTV to be used in community placements as a tool to safeguard their loved ones and a means of developing and improving learning. Furthermore, it is necessary to have a proper regional policy on CCTV that will ensure consistency of approach irrespective of the nature or location of the placement or the identity of the provider.

154. There are many ongoing and specific issues with CCTV that our clients ask the Inquiry to engage with and address. In the first instance, they have not been permitted to view the CCTV of their loved ones' abuse in MAH. While some do not want to see it, others do and for them it is a matter of torment to be left with only their mental images from the evidence of others about what happened to their loved ones. The feel they should be able to view it and believed it would happen in line with the hope expressed by the Chair in his opening statement[178]. They ask the Inquiry to make a formal finding that they should be entitled to view the CCTV if they wish to do so.

155. More generally, there is an issue in community placements with service providers retaining ownership or control of CCTV footage, such that residents and their families must seek their permission to view the CCTV. This has the potential for a real conflict as the provider retains control of the very material that is required to hold the provider to account and ensure they are providing the necessary standard of care. Such a state of

affairs should not be tolerated any longer. Our clients seek a recommendation from the Inquiry that patients and their families have a right to access to CCTV that relates to them. There is also an issue with the length of time for which CCTV is available before it is overwritten[179]. There is no consistency over this in community placements. In some cases, it can mean that the relevant footage is lost before it can be used as intended. Accordingly, our clients seek a recommendation that any regional policy must provide for the retention of CCTV for an appropriate, standardised period in order that it can be effective as a safeguarding tool. Our clients will seek to deal with these and further aspects of CCTV within the resettlement session.

(vii) Regulator

156. The problems with RQIA are similar to those within the BHSCT and Department that contributed to their failures in leadership and governance. High quality processes and procedures are no substitute for the right people with the right knowledge and attitude. The RQIA's oversight must not merely be a superficial, box-ticking exercise, with inspectors lacking in suspicion and satisfied by the bare minimum. It must be a rigorous process. They must proactively seek a range of streams of high-quality evidence (including from families and from effective Advocacy Services) which provides strong and coherent assurance as to the quality of care. Our clients seek a finding to that effect and recommendations to help make that a reality.

(viii) Advocacy

157. Individuals and their families need a strong, effective advocacy service that is well-known and proactively made available. Our clients ask the Inquiry to endorse the recommendations set out in the statement of 4 March 2024 made on behalf of the PCC by its current Chief Executive Officer Meadhbha Monaghan[180], particularly those on the independence of advocacy services. This is especially important given the evidence of Bryson House that they would sometimes be reminded that their contract was with the BHSCT[181].

(ix) Culture

158. Our clients are firmly of the view that there must be a cultural change within the system. Learning Disability can no longer be a "Cinderella service". There must be proper recognition of the importance of Learning Disability Services. Accordingly, they consider

that the Inquiry's recommendations must address the need to embed this message throughout the system, at every stage, and at every level.

(x) Regulation of Healthcare Assistants

159. There is an urgent need for formal regulation of Healthcare Assistants to ensure that those who have been involved in abuse and neglect cannot continue working in learning disability services simply by moving jobs. Our clients seek findings and recommendations on this.

(xi) Duty of Candour

160. Recommendations have previously been made from at least 2024 for the introduction of a statutory duty of candour[182]. Following on from the Health Minister's pledge to introduce an organisational duty of candour[183], there is currently an ongoing consultation on the issue. Nevertheless, the reality is that Northern Ireland remains the only part of the UK not to have introduced such a duty of candour. Our clients consider that should happen as a matter of urgency and invite the Inquiry to reflect that in its recommendations as was done in the 2018 report of the Hyponatraemia Inquiry and the 2020 report of the Dunmurry investigation.

(xii) Adult safeguarding legislation

161. There is currently an Adult Safeguarding Bill, but it has not been passed over a prolonged period. There must be an Adult Safeguarding Act passed into law as a matter of urgency. Our clients consider that the evidence demonstrates there is a need to place adult safeguarding provision on a statutory footing and they seek a finding and recommendation for an Adult Safeguarding Act passed into law as a matter of urgency.

(xiii) Resettlement and Community Based Learning Disability Services

162. In general, it is submitted on behalf of our clients that what is required is clear: a properly resourced, properly staffed, properly governed and regulated, system of community-based learning disability services. This will require increases in funding, coherent staff planning, improvements in governance and oversight, and the provision of additional services.

163. However, the further session relating to these matters is yet to take place. Our clients are strongly of the view that the Inquiry cannot make properly targeted and effective

recommendations with respect to these matters without further information on the up-to-date position in the community. This is a matter of key importance to our clients because it goes to the current safety and wellbeing of their loved ones as well as into the future. In these circumstances, our clients will seek to provide further closing submissions on resettlement and community-based learning disability services once the further sessions are complete and the further material is made available.

(xiii) Accountability

164. Our clients consider that for the most part save for frontline staff, the actions, omissions and failures that caused the abuse have been perpetrated with complete impunity. That has to be rectified. To ensure the failures at MAH do not happen again, it is essential that there is an adequate investigation capable of ensuring the accountability of all those responsible for the abuse. Individuals in MAH were subjected to treatment contrary to Articles 2 and 3 ECHR. Thus, the state has a positive obligation to conduct an investigation that is independent, adequate, conducted promptly and with reasonable expedition, and conducted with the necessary element of public scrutiny and participation of the Next-of-Kin.

165. Our clients ask the Inquiry to formally recommend that a dedicated mechanism is set up that has the capacity to investigate the individual allegations with respect to individuals in MAH. Such capacity to investigate must not be limited merely to the frontline staff responsible for actively perpetrating abuse, but to discharge the investigative duties under Articles.2 and 3 ECHR must be capable of securing accountability of all those who failed to discharge their responsibilities in ways that could have prevented the abuse. Our clients contend that such a mechanism could be operated both to secure accountability of those responsible and also as a scheme to assess the harm caused as a result of the abuse and to make appropriate remedial provision.

Redress Scheme

166. The Inquiry has heard extensive evidence of the traumatic impact that the abuse at MAH has had upon patients and their families. Our clients submit that there is a need for a dedicated redress scheme for individuals who were resident in MAH and for their families and they ask the Inquiry to make that recommendation as provided for in its Terms of Reference. Such a scheme could be operated as part of the accountability mechanism identified above and should have 2 primary purposes with respect to the remedial function to: (i) provide a dedicated mechanism for considering and identifying the full

impact of the abuse on individuals and their families and identifying the necessary support, treatment, and counselling that is required to address, mitigate and reduce that impact; and (ii) provide redress, including financial redress, for the personal injury, loss and damage caused to individuals in MAH and their families, which needs to properly reflect the gravity and duration of the abuse suffered.

THE INQUIRY PROCESS

167. Public inquiries have become an increasing feature of public life when the public sector gets it badly wrong, and people are harmed. Rarely, are the views of those whose experience prompted the Inquiry heard on the processes adopted for actually delivering on its Terms of Reference; and yet the success of that process has the capacity to do considerable good, over and above the findings and recommendations that the Inquiry makes. In this regard our clients want to make clear that they found the Inquiry to be a challenging process. They anticipated that it would be very hard to relive their experiences and hear some of the evidence, but they did not reckon that it would otherwise be so difficult. They refer to the following 5 aspects with a view to constructively identifying matters they hope will assist future investigations.

(i) Failure to put patients and families at the centre of the process

168. This Inquiry came about through the campaign by our clients, the families of MAH patients affiliated to AFM and SPFMAH. Too often, they had found previous processes to be obstructive and opaque, with few people properly listening to what they had to say. It was therefore important to them that the examination of abuse at MAH was carried out in public and that their voice was properly heard.

169. Regrettably their experience of the Inquiry's processes has at times also been one where they have not felt they were viewed as important or essential notwithstanding continual statements to the contrary by the Inquiry such as: *"I regard the patients and their relatives and carers who have been abused, or received poor care, as being at the front and centre of this Inquiry."*[184] They do not consider this was demonstrated in practice, for example:

    a. difficulties with the statement-taking process when the Inquiry required them to have their statements taken by individuals they did not know and with whom they had developed no relationship of trust, which although ultimately modified was a bad start as by then a lot of worry and frustration had built up,

b. provision of large volumes of important documentation only shortly in advance of evidence sessions, which made it difficult for them to absorb and to provide instructions in time to be of use,
c. restrictions on downloading and receiving hard copies of materials where electronic viewing for them was problematic,
d. hearings that could only be viewed in real time when some were at work or otherwise engaged,
e. questions submitted for witnesses without any mechanism for confirming beforehand which of their suggestions were accepted and if not the reason,
f. correspondence raising important issues that went unanswered or unaddressed (such as the correspondence asking about the Chair's indication that expert evidence would be the final part of the Inquiry),
g. failure of the Inquiry to make use of its power to make interim recommendations without any proper engagement or explanation.

170. As a result, many of them, including those who are elderly or who continue to have significant caring responsibilities, felt unable to properly engage with vital material that was often dealing with their loved ones or issues they had specifically raised and therefore had a clear interest in following how the evidence was delivered. These points were made on their behalf in correspondence many times over the course of the Inquiry but met with little change.

171. Our clients are fully aware of the difficulties which are inherent in any public inquiry, and the inevitable need for processing of large volumes of documentation within relatively short timeframes. They are also fully aware of the importance in this Inquiry of avoiding any steps that could frustrate or detract from the criminal justice process. They, more than anyone, are concerned to ensure the integrity of that process. However, they consider it would have been possible to find practical ways of addressing their concerns and they were left with the feeling that the failure to do so indicated the Inquiry's true view of their significance of their role, which although characterised as to "*further the work of the Inquiry and assist it in fulfilling to carrying out its Terms of Reference"*, did not feel like that to them.

172. As a result, whether justified or not, the message our clients took from the Inquiry's approach to evidence in general was that the Inquiry considered it had the necessary

expertise to gather information and analyse the issues, and did not need to engage with our clients' assessment of the evidence. This was redolent of their experience with MAH and the BHSCT. As a result, many lost faith in the Inquiry they had fought so hard to bring about.

(ii) Information gathering rather than accountability

173. One of the key aims of our claims in campaigning for the Inquiry was to secure the accountability of those responsible for the abuse of their loved ones. They were particularly concerned to ensure that those in positions of leadership and management were held to account for the prolonged and egregious abuse perpetrated under their authority and which engaged their responsibilities under both Articles 2 and 3 ECHR as was stated in their opening: "*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."*[185]

174. In the event, it appears to our clients that the evidence sessions were approached as an information gathering exercise, with witnesses for the most part being treated and questioned as information providers rather than as the people who had authority in and over MAH, who thus bear a high level of responsibility for the abuse which was perpetrated, and who should be held accountable accordingly. For our clients this omitted the important function of publicly holding those who are responsible to account and using these sessions to recover some to the public's loss of trust and confidence in the health and social care system.

175. For our clients this was starkly demonstrated by the Inquiry's approach to evidence from Professor Sir Michael McBride. Initially the Inquiry did not propose to call him to give oral evidence on the basis that his statement was sufficient. Our clients simply could not understand this given the fact that he was double jobbing as CMO and BHSCT Chief Executive at a key time just prior to the abuse scandal breaking. It caused particular anger. Even when ultimately the Panel agreed to call him, it did so stating: *"The Panel remains of the view that this witness is very unlikely to be able to contribute more than what is already contained in his written evidence. However, in the interest of working together with Core Participants the Panel have decided to invite Professor Sir Michael McBride to attend the Inquiry in order to provide oral evidence in answer to Core Participant questions. I confirm that one hour will be set aside…purely for Core*

Participant questions to be posed to the witness through Counsel to the Inquiry. The topics upon which Professor Sir Michael McBride will be questioned must be furnished to the inquiry…and, in light of the very short notice, shall be forwarded to Professor McBride."[186] Unfortunately, this statement only exacerbated matters not least because the one hour was set before the Inquiry had received any proposed questions.

176. For our clients, the apparent deference shown to this witness was both inappropriate and unwarranted. For them, the approach failed to appreciate the essential role the Inquiry has in holding relevant individuals publicly to account. As a result, the Inquiry's claim that it was calling Professor Sir Michael McBride "*in the interest of working together with Core Participants*" was unfortunately viewed as patronising – in essence, the Inquiry was calling the witness, not because the Inquiry considered him to be relevant, but to allow Core Participants to ask questions which the Inquiry expressly viewed as irrelevant. In the event, he attended to give evidence, his oral evidence went further than his written statement and his evidence was reported that evening as the main headline on BBC News Online. Bluntly, this would not have happened if he had not been called to give oral evidence.

177. Many of our clients feel the Inquiry has failed to give adequate weight to the importance of public accountability as a core aspect of the Inquiry's role. They feel the Inquiry has almost completely failed to discharge that important aspect of the function of a public inquiry. In contrast, they look at the Post Office Inquiry, and the Covid-19 Inquiry, which, in their view, are both clearly and obviously aware of their function in holding those with responsibilities publicly to account, and managed (and continue to manage) to hold the public's attention over a prolonged period.

(iii) Timing of the hearings

178. March 2023 to June 2023, was spent on what was stated to be an information gathering exercise describing and explaining structures and law and was not focused on the effectiveness of the legislation, policies and regulations or where they failed.[187] However, when it came to the Inquiry modules that were focused on the actual failures at MAH by leadership and management, our clients considered insufficient time was made for that crucial evidence. The ten Organisational Modules started at the very end of May 2024 and were completed over approximately 8 weeks in June, September and October (interspersed with staff and other evidence). Large volumes of documentation were

disclosed with little time for Core Participants to engage with or analyse the material, notwithstanding repeated requests in correspondence for earlier provision of the hearing schedule and the associated documents, specifically to avoid that problem. The oral evidence from the RQIA was limited to just 2 evidence sessions. The module on resettlement opened on 24 June and closed on 25 June. Only 2 days and 2 half days were spent on the BHSCT Board. The Department's evidence was 3½ days.

179. In the circumstances, our clients are left feeling that the most important part of the Inquiry has been rushed over, with little opportunity for their consideration or input.

(iv) Changing approach

180. At times the Inquiry would change its approach without identifying that it had done so or explaining its reasoning. For example, in the Chair's Statement issued on 13 February 2023, the Inquiry outlined its plan for the remaining evidence, including Patient Experience, Staff, and relevant Authorities, and expressly stated at paragraph 14 that, *"The final area of evidence to be received will be expert evidence on a number of different topics to assist the panel on potential recommendations."* Following the Chair's subsequent statement of 12 December 2023 dealing with the plan for 2024, correspondence was sent on behalf of our clients asking whether there was a preliminary schedule of experts from whom the Inquiry intends to hear. No response to this query was received and the Inquiry appeared to have changed its plan to have an evidence session dedicated to expert evidence on a number of different topics. Our clients do not know why. In their view, evidence from appropriate experts could have provided a valuable input to the Inquiry.

181. The only true expert evidence received by the Inquiry was from Alexander Ruck Keene KC, which demonstrated the value experts could provide to the Inquiry. The use of experts could have assisted in explaining the regular reference in the evidence to matters that could not properly be engaged with or understood by the public such as the 'Swiss Cheese Model' of risk management and the approach to risk management in the aviation industry, as well as the complex issues involved in 'governance and assurance'. While our clients do not doubt the expertise of the Inquiry, it is not sufficient for a public inquiry to have expertise itself. It must examine the issues in a manner that can be engaged with and understood by the Core Participants and the public.

(v) The requirement to file closing submissions prior to the resettlement session

182. Our clients, some of whose loved ones are still in MAH awaiting discharge to a community placement, requested an opportunity to provide further information to the Inquiry on discharge and resettlement. In response, the Inquiry decided to have a separate session on 'resettlement'. However, the Inquiry is proposing to conduct this session as information gathering, rather than as an evidence session, and to schedule it after these closing submissions are provided.

183. The issue of resettlement into community placements is of vital importance to our clients in enabling the Inquiry to make recommendations that will ensure the safety and well-being of their loved ones for the future and others with mental health issues and learning disabilities. Given that the evidence sessions on resettlement during the Organisational Modules lasted only 1½ days, our clients consider it is important that closing submissions can be made on the totality of the discharge and resettlement material provide to the Inquiry to inform its delivery of its Terms of Reference and making recommendations. However, the Inquiry has proceeded with closing submissions ahead of the resettlement and available community services sessions, so our clients look forward to making submissions at the end of those sessions.

Conclusion on the Inquiry process

184. From our clients' perspective the purpose of a public Inquiry is not simply to gather the evidence and make appropriate findings and recommendations, but that where, as here, it is dealing with egregious breaches of the most serious human rights, the proper inclusion of families in the process is an essential end in itself. This is particularly where the abuse scandal has caused a loss of trust (amongst our clients and the public) and a key purpose of the Inquiry is to try and restore trust and confidence in the system.

OVERALL CONCLUSION

185. To sum up, our clients believe that there can be little doubt that the most serious abuse was perpetrated against the most vulnerable of people over a prolonged period. It should be a matter of shame for all involved. Staff, management, leadership and oversight bodies repeatedly came before the Inquiry and expressed shock at the abuse. They had faith in their governance systems and say that they had no idea how it could have happened. They say that they still have no idea. They say that they are looking to the Inquiry to tell them what to do to stop the abuse from happening again.

186. For many of our clients, this failure of leadership and management to understand what they were doing wrong, or to understand their own responsibility for the abuse perpetrated at MAH, is gravely concerning. It means that there can be little confidence in their ability to make the necessary changes to prevent the abuse in future.

187. It also means that, in all likelihood, the abuse would have continued if not for the CCTV (which had initially been installed not to protect patients but rather to make it easier for staff to defend themselves against allegations of abuse), and if not for the rigorous efforts of P96's father to gain access to the CCTV.

188. That is why the forthcoming sessions on resettlement and available community services are so important. For many of our clients, their community placements are as bad as – or in some cases worse - than their experience at MAH, and yet there continues to be no understanding or awareness of what is going wrong or how to improve it. Our clients regard it as essential that the Inquiry identifies the position in the community and makes strong, effective recommendations, capable of ensuring such abuse cannot happen in the community placements.

TRIBUTE TO GERALDINE O'HAGAN

189. Finally, our clients wish to conclude these submissions to the Inquiry by paying tribute to Geraldine O'Hagan. The Inquiry is well aware of the special role that she played for families and patients. The support that she provided, the consideration that she gave, and the care that she showed to them, stands in stark contrast to the treatment that our clients and their loved ones experienced from others connected to MAH. She went above and beyond to advocate for them and to care for them, even sacrificing her time, in her final days, to give evidence to the Inquiry, in order that their welfare and safety could be assured into the future.

190. If the Department, BHSCT, RQIA and other Health and Social Care bodies and personnel wish to understand the type of attitude that is required, and the qualities that are needed, to provide the proper levels of care and safety for our clients' loved ones, they need do nothing more than look to the example of Geraldine O'Hagan. So far as our clients are concerned, she exemplifies everything that the system must strive to achieve.

Monye Anyadike-Danes KC

Aidan McGowan, Amy Kinney, Hannah Cullinan

1 Margaret Flynn, STM-108-4 at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Flynn%2C%20Margaret%20-%20Statement.pdf

2 Transcript of 08.06.2022, p.36. All the transcripts to which we refer in this closing are available on the Inquiry's website at https://www.mahinquiry.org.uk/hearings#toc-1

3 Terms of Reference, Core Objectives, para.1.c

4 Cathy Jack, STM-287-19, para.64, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M09%20-%2003%20-%20Jack%2C%20Cathy%20-%20Statement%20%2824.06.14%20%29.pdf

5 Cathy Jack, STM-287-18, para.61, *supra*

6 https://www.health-ni.gov.uk/about-department-health

7 Article 4, Departments (Northern Ireland) Order 1999 at https://www.legislation.gov.uk/nisi/1999/283/article/4

8 Margaret Flynn, STM-108-4 *ibid*; NI Assembly debate, Public Inquiry into Muckamore Abbey Hospital, 12:00, 8 September 2020 at https://www.theyworkforyou.com/ni/?id=2020-09-08.1.116; David Bingham, STM-115-4 https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Bingham%2C%20David%20-%20Statement.pdf ; *JR222 v Minister of Health* [2022] NICA 57 at para 3, at https://www.judiciaryni.uk/files/judiciaryni/decisions/JR222%27s%20Application%20and%20Minister%20of%20Health.pdf

9 https://www.irishtimes.com/life-style/people/2022/06/11/give-me-a-crash-course-in-the-muckamore-scandal /

10 https://www.ppsni.gov.uk/news/pps-issues-further-decisions-muckamore-abbey-hospital-files#:~:text=This%20brings%20the%20number%20of,patients%20at%20Muckamore%20Abbey%20Hospital. https:// See too: www.nursingtimes.net/learning-disabilities/muckamore-nurses-appear-to-be-among-latest-defendants-22-01-2025/

11 Operation Turnstone is not complete, and numbers could change as the PSNI continues to investigate.

12 Transcript of 16.10.2024, p.104

13 See for example Geraldine O'Hagan, Transcript 15.05.2024, p.78 and 127

14 See ROs. involving our clients: no.18 (P60's sister), no.19 (P109's mother), no.21 (P119's mother), no.22 (P122), no.23 (P110's mother), no.24 (P34's mother and sister), no.25 (P118's mother), no.26 (P117's parents), no.27 (P36's parents), no.28 (P121's sister), no.29 (P96's father). See too other RO: nos. 32 & 33 (A4), nos.31 & 34 (A3), nos.35 & 37 (A5), 36 (A6), nos.38 & 39 (A7), nos.40 & 41 (A8), nos.42 & 43 (A9)

15 Transcript, 23.09.24, p185, L.3-27

16 Transcript for 12.10.2023, p.13-14; See also P117's mother, Transcript 10.10.2023, p.16 P109's mother, Transcript 21.09.2023, p.9

17 Transcript of 20.09.2023, p.13-14

18 Transcript for 11.10.2023, p.79

19 Dr Joanna Dougherty, STM-123-4, paras 13 – 30, https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-03/Dougherty%2C%20Joanna%20-%20BHSCT.pdf

20 Transcript for 28.09.2023. p.18

21 Whilst we give some examples the Inquiry should also be aware of and bear in mind evidence from our other clients e.g. the following transcripts of evidence: P34's mother and sister on 09.10.2023:, P77's mother and aunt on 20.06.2023, P90's sister and brother on 11.10.2023, P96's father on 11.10.2023, P99's nephew on 14.09.2023, P101's mother on 13.09.2023, P104 on 14.09.2023, P105's mother on 14.09.2023, P107's brother on 27.09.2023, P109's mother on 20.09.2023, P110's mother on 28.09.2023, P115's father on 27.09.2023, P116's mother on 11.10.2023, P117's parents on 10.10.2023, P118's mother and sister on 09.10.2023, P119's mother on 28.09.2023, P128's father on 25.09.128, P120's father on 20.09.2023

22 Transcript of 20.09.2023, p.108 and 110

23 Transcript of 14.09.2023, p.32 and 33

26. Transcript of 25.09.2023, p.11-12

[25] Transcript of 14.11.2023, p.87-88
[26] Transcript of 20.09.2023, p.37-38
[27] Transcript of 08.02.2024, p.12-13
[28] Whilst we give some examples the Inquiry should also be aware of and bear in mind evidence from our other clients e.g. the following transcripts of evidence: P34's mother and sister on 09.10.2023, P60's sister on 20.09.2023, P77's mother and aunt on 20.06.2023, P90's sister and brother on 11.10.2023, P96's father on 11.10.2023, P99's nephew on 14.09.2023, P101's mother on 13.09.2023, P102's brother on 14.09.2023, P107's brother on 27.09.2023, P115's father on 27.09.2023, P116's mother on 11.10.2023, P118's mother and sister on 09.10.2023, P119's mother on 28.09.2023, P123's sister on 28.09.2023, P124's mother on 20.09.2023, P128's father on 25.09.128
[29] Transcript of 11.10.2023, p.102
[30] Transcript of 20.09.2023, p.117
[31] Transcript of 11.10.2023, p.91
[32] Transcript of 14.09.2023, p.34
[33] Transcript of 20.06.2023, p.36
[34] Whilst we give some examples the Inquiry should also be aware of and bear in mind evidence from our other clients e.g. the following transcripts of evidence: P34's mother and sister on 09.10.2023, P60's sister on 20.09.2023, P105's mother on 14.09.2023, P110's mother on 28.09.2023, P115's father on 27.09.2023, P116's mother on 11.10.2023, P118's mother and sister on 09.10.2023, P123's sister on 28.09.2023
[35] Transcript of 21.09.2023, p.23
[36] Transcript of 12.10.2023, p.21
[37] Transcript of 09.10.2023, p.109. See also P34's mother's statement at p.27 of the same Transcript
[38] Whilst we give some examples the Inquiry should also be aware of and bear in mind evidence from our other clients e.g. the following transcripts of evidence: P34's mother and sister on 09.10.2023, P115's father on 27.09.2023, P124's mother on 20.09.2023
[39] Transcript of 27.09.2023, p.53.
[40] Transcript of 09.10.2023, p.55.
[43] Transcript of 20.06.2023, p.55.
[42] Whilst we give some examples the Inquiry should also be aware of and bear in mind evidence from our other clients e.g. P101's mother, Transcript of 13.09.2023, p.55; P105's mother, Transcript of 14.09.2023, p.51; P115's father, Transcript of 27.09.2023, p.53).
[43] Transcript of 20.06.2023, p.39
[44] Whilst we give some examples the Inquiry should also be aware of and bear in mind evidence from our other clients e.g. the following transcripts of evidence: P34's mother and sister on 09.10.2023, P60's sister on 20.09.2023, P77's mother and aunt on 20.06.2023, P90's sister and brother on 11.10.2023, P96's father on 11.10.2023, P99's nephew on 14.09.2023, P101's mother on 13.09.2023, P105's mother on 14.09.2023, P109's mother on 20.09.2023, P110's mother on 28.09.2023, P115's father on 27.09.2023, P117's parents on 10.10.2023, P119's mother on 28.09.2023, P120's father on 20.09.2023.
[45] Transcript of 22.09.2022, p.23
[46] Transcript of 23.09.2024, p.136.
[47] Transcript of 9 October 2023, p.114
[48] Transcript of 11 October 2023, p.108
[49] Whilst we give some examples the Inquiry should also be aware of and bear in mind evidence from our other clients e.g. the following transcripts of evidence: P34's mother and sister on 09.10.2023, P60's sister on 20.09.2023, P77's mother and aunt on 20.06.2023, P90's sister and brother on 11.10.2023, P96's father on 11.10.2023, P101's mother on 13.09.2023, P104 on 14.09.2023, P105's mother on 14.09.2023, P109's mother on 20.09.2023, P110's mother on 28.09.2023, P115's father on 27.09.2023, P116's mother on 11.10.2023, P117's parents on 10.10.2023, P118's mother and sister on 09.10.2023, P120's father on 20.09.2023, P122 on 28.09.2022, P124's mother on 20.09.2023.
[50] Transcript of 20.06.2023, p.154; Transcript of 27.09.2023, p.43.
[51] Transcript of 20.09.2023, p.100
[52] Transcript of 20.09.2023, p.121
[53] Transcript of 20.09.2023, p.34
[54] Transcript of 21.09.2023, p.34
[55] Whilst we give some examples the Inquiry should also be aware of and bear in mind evidence from our other clients e.g. the following transcripts of evidence: P34's mother and sister on 09.10.2023, P60's sister on 20.09.2023, P77's mother and aunt on 20.06.2023, P90's sister and brother on 11.10.2023, P110's mother on 28.09.2023, P116's mother on 11.10.2023, P117's parents on 10.10.2023, P119's mother on 28.09.2023, P122 on 28.09.2022, P124's mother on 20.09.2023

[56] See e.g. P77's mother's evidence, Transcript of 20.06.2023, p.54; and P60's sister's evidence, Transcript 20.09.2023, p.27
[57] Transcript of 19.02.2024, p.36
[58] Transcript of 08.06.2023, p.124f
[59] Transcript of 08.06.2023, p.125-126
[60] Transcript of 07.06.2023, p.44-45
[61] Transcript of 07.06.2023, p.43
[62] Transcript of 11.10.2023, p.110; Transcript of 27.09.2023, p.110.
[63] Transcript of 14.11.2023, p.90-92
[64] Transcript for 20.09.23, p27
[65] Marie Heaney, STM-301-47, para 193-194, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M07%20-%2006%20-%20Heaney%2C%20Marie%20-%20Statement%20%2824.07.02%29.pdf
[66] In addition to the reports such as the serious case reviews into abuses at Winterbourne View (2023) and Whorlton Hall (2023) in England, see as examples from this jurisdiction: Independent Review of the Action Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House, Carrickfergus (July 2014); NICE Guidance, Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning disabilities whose Behaviour Challenges (May 2015); Report of the Historical Institutional Abuse Inquiry (January 2017); Report of the Inquiry into Hyponatraemia-related Deaths (January 2018), A report on the Commissioner's Investigation into Dunmurry Manor Care Home (June 2018); A Review of Leadership & Governance at Muckamore Abbey Hospital (July 2020)
[67] Transcript of 20.09.2023, p.24
[68] See para.7, item 6, Chair's Statement of 12 September 2023, at Chair's Statement for 12 September 2023.pdf
[69] Mairead Mitchell, STM-240-5, para.25, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-08/M07%20-%2008%20-%20Mitchell%2C%20Mairead%20-%20Statement%20%2824.04.25%29.pdf
[70] Transcript of 20.09.2023, p.46
[71] Transcript of 20.09.2023, p.46-47
[72] Transcript of 22.09.2022, p.28
[73] Transcript of 20.09.2023, p.99
[74] See by way of example the evidence of Aine Morrison, statement no.2 STM-198-4, para.13 *et seq*, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/Morrison%2C%20Aine%20-%202nd%20Statement2.pdf
[75] See e.g. P77's mother. See also Transcript of 23.10.2024, p.5. See also RQIA Inspection Report 19 July 2023 – 30 May 2024, requested by Strategic Planning and Performance Group (SPPG) to undertake a retrospective review of previous adverse incidents and MAH, at https://www.rqia.org.uk/RQIA/media/CareServices/020426_MuckamoreAbbeyHospital_Care_19072023.pdf
[76] See a compiled chronology of relevant events at Appendix III to this opening, which builds on the chronology accompanying the written opening of AFM and SPFMAH.
[77] Such as for the 2018 Way to Go report and the 2020 Leadership & Governance report at Margaret Flynn, STM-108-4, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Flynn%2C%20Margaret%20-%20Statement.pdf and David Bingham, STM-115-4, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Bingham%2C%20David%20-%20Statement.pdf respectively.
[78] Sean Holland, STM-297-333, Exhibit 31, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M10%20-%2001%20-%20Holland%2C%20Sean%20-%20Exhibits%2020-50.pdf
[79] Peter McNaney, STM-302-15, para.40, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M09%20-%2001%20-%20McNaney%2C%20Peter%20-%20Statement%20%2824.07.03.%29.pdf
[80] Transcript of 16.10.2024, p.107
[81] Transcript of 21.10.2024, p.65
[82] Martin Dillon, STM-272-339, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-08/M09%20-%2004%20-%20Dillon%2C%20Martin%20-%20Statement%20%2824.05.30%29.pdf
[83] David Bingham, STM-115-135, para.8.81 *et seq*, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Bingham%2C%20David%20-%20Statement.pdf

[84] Jill Duffie, STM-337-18, Exhibit 5, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-11/PSNI%20-%20Jill%20Duffie%20-%2024.10.25_0.pdf

[85] Esther Rafferty, STM-229-24, Exhibit 1, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Rafferty%2C%20Esther%20-%20Statement.pdf

[86] Mark McGuicken, STM-089-1412, Exhibit MMcG-36, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-03/9McGuicken%2C%20Mark%20-%20Exhibits%2036%20and%2037%20Pages%201412%20-%201703.pdf

[87] Transforming Your Care: A Review of Health and Social Care in Northern Ireland, December 2011, DHSSPS, p.92, at https://www.socialfarmingacrossborders.org/images/custom/uploads/40/files/transforming-your-care-review-of-hsc-ni-final-report.pdf. See referenced in Chris Hagan, STM-105-5, https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-03/Hagan%2C%20Chris%20-%20BHSCT%20%28addendum%29.pdf

[88] See at https://www.northernireland.gov.uk/sites/default/files/publications/nigov/pfg-2008-11.pdf. Further examples can be seen in the chronology at Appendix III

[89] Transcript for 21.10.2024, p.37

[90] Winterbourne View Hospital: A Serious Case Review, p.122, at https://sites.southglos.gov.uk/safeguarding/wp-content/uploads/sites/221/2023/07/WV-SCR-report.pdf

[91] Cathy Jack, STM-287-19 and 20, paras.63 *et seq*, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M09%20-%2003%20-%20Jack%2C%20Cathy%20-%20Statement%20%2824.06.14%20%29.pdf

[92] See the evidence of those read into the record, Transcript of 12.10.2023, p.43, 54, 61

[93] Sean Holland, STM-297-188, Exhibit 18, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M10%20-%2001%20-%20Holland%2C%20Sean%20-%20Exhibits%2020-50.pdf :

[94] Tracy Hawthorne, STM-326-3, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M04%20-%2004%20-%20Hawthorne%2C%20Tracy%20-%20Statement.pdf

[95] Press statement of 5 August 2020, at https://www.health-ni.gov.uk/news/independent-review-muckamore-published

[96] Transcript of 11.10.2023, p.16-17

[97] See e.g., para.8, Chair's Statement on Staff Evidence and Remaining Phases (2 November 2023), at Chair's Statement on Staff Evidence And Remaining Phases (2 November 2023) | Muckamore Abbey Hospital Inquiry

[98] See *Finucane's Application* [2019] UKSC 7 at para.127

[99] Review of Mental Health and Learning Disability (Northern Ireland) chaired by Professor David Bamford, (2005) Equal Lives: Review of Policy and Services for people with a Learning Disability in Northern Ireland, Department for Health, Social Service and Public Safety, at Roy McClelland, STM-083-315, Exhibit T2.02, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2023-11/Professor%20Roy%20McClelland%20-%20Tab%202.pdf

[100] Roy McClelland, STM-083-318, Exhibit T2.02, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2023-11/Professor%20Roy%20McClelland%20-%20Tab%202.pdf

[101] Transcript of 22.10.2024, p.142 *et seq*

[102] Mark McGuicken (fourth addendum) STM-333-5 *et seq*, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-11/McGuicken%2C%20Mark%20-%20DOH%20%28Fourth%20Addendum%20Statement%29.pdf

[103] See for example the evidence of Richard Pengelly, Transcript of 23.10.2024, at p.112 *et seq*, at *ibid*

[104] Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland, September 2005, Foreword ii, Roy McClelland, STM-083-318, Exhibit T2.02, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2023-11/Professor%20Roy%20McClelland%20-%20Tab%202.pdf. See too Presentation by Roy McConkey, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2023-11/Professor%20Roy%20McConkey%20Presentation.pdf

[105] Roy McClelland, STM-083-3, para.11, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2023-12/Professor%20Roy%20McClelland%20-%20Statement%20and%20Exhibits%20List_0.pdf and referenced interview with the BBC, 18 January 2019, at https://www.bbc.co.uk/news/uk-northern-ireland-46909885

[106] See Review of Policy for People with a Learning Disability, Section 5: Care in the Community at STM-089-1444 *et seq*. Exhibit MMcG-36, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-03/9McGuicken%2C%20Mark%20-%20Exhibits%2036%20and%2037%20Pages%201412%20-%201703.pdf

[107] See Equal Lives, Chapter 3, para.3.17 *et seq* at Roy McClelland, STM-083-336, Exhibit T2.02, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2023-11/Professor%20Roy%20McClelland%20-%20Tab%202.pdf

[108] Review of Policies and Procedures to Safeguard Children and Vulnerable Adults in Muckamore Abbey Hospital completed in December 2005. See Miriam Somerville, STM-112-3, Exhibit MS/1, STM-112-4, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Somerville%2C%20Miriam%20-%20Statement.pdf

[109] Sean Holland, STM-297-189, Exhibit 18, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M10%20-%2001%20-%20Holland%2C%20Sean%20-%20Exhibits%201-18_0_.pdf

[110] Miriam Somerville, STM-112-5, Exhibit MS.1, 'Review of Policies and Procedures to Safeguard Children and Vulnerable Adults in Muckamore Abbey Hospital', at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Somerville%2C%20Miriam%20-%20Statement.pdf

[111] See for example P107 (admitted in 1961 and discharged in 2014); P22 (admitted in 1969 and discharged in 2018); P118 (first admitted in 1983 and finally discharged in 2017).

[112] See for example Bria Mongan, STM-233-4, Exhibit 1, Independent Review of the Learning Disability Resettlement Programme in Northern Ireland, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/M06%20-%2007%20-%20Mongan%2C%20Bria%20-%20Statement.pdf

[113] Sean Holland, STM-297-186 *et seq*, Exhibit 18, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M10%20-%2001%20-%20Holland%2C%20Sean%20-%20Exhibits%201-18_0_.pdf

[114] Better Government for Northern Ireland: Final Decisions of the Review of Public Administration, Securing our Future, March 2006, at https://cain.ulster.ac.uk/issues/policy/publicadmin/rpani210306.pdf

[115] Mark McGuiken, STM-089-7, paras.2.26 to 2.29, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-03/1McGuicken%2C%20Mark%20-%20Statement%20and%20index%201%20-%2089.pdf

[116] Cathy Jack, STM-287-2, paras.8 to 10, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M09%20-%2003%20-%20Jack%2C%20Cathy%20-%20Statement%20%2824.06.14%20%29.pdf

[117] Transcript of 17.10.2024, p.116-117

[118] See for example David Bingham, Transcript of 18.06.2024, p.84

[119] Transcript of 16.10.2024, p.77, 94

[120] Aidan Dawson, Transcript 03.04.2023, p.101, L.25 and p.102, L.22, p.103, L.29.

[121] Ennis-1-82, BHSCT Follow-up Proforma for Early Alert Communication, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-11/Module%206b%20Ennis%20Bundle.pdf. See too Brendan Whittle, STM-277-13, para.36, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M10%20-%2004%20-%20Whittle%2C%20Brendan%20-%20Statement%20and%20Exhibits%201-13.pdf. Charlotte McArdle was appointed to the position of Chief Nursing Officer on 5 April 2013 and her evidence is that she knew nothing of this. See STM-294-46, para.140, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-08/M10%20-%2002%20-%20McArdle%2C%20Charlotte%20%28Prof.%29%20-%20Statement%20Only%20%2824.06.28%29.pdf. There seems to be no evidence from her predecessor.

[122] See e.g., June Champion, STM-088-1332, Exhibit Tab.12, Report of the Committee on the Financial Aspects of Corporate Governance (Cadbury Report), Dec.1992 at STM-088-1332, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-03/12%20Champion%2C%20June%20-%20Tab%2012.pdf. See too, transcript of 18.06.2024, p.83, 120

[123] See Brendan Whittle, STM-277-13, para.36, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M10%20-%2004%20-%20Whittle%2C%20Brendan%20-%20Statement%20and%20Exhibits%201-13.pdf

[124] Brendan Whittle, STM-277-14, *supra*

[125] Martin Dillon, STM-272-338 *et seq*, Exhibits T04.2 and T04.4, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-08/M09%20-%2004%20-%20Dillon%2C%20Martin%20-%20Statement%20%2824.05.30%29.pdf

[126] Margaret Flynn, STM-108-4, exhibit MF/1, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Flynn%2C%20Margaret%20-%20Statement.pdf

[127] Margaret Flynn (no.2), STM-117-4, Exhibit MF/2, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Flynn%2C%20Margaret%20-%20Second%20Statement.pdf
[128] Transcript of 25.05.2023, p.11, 19, 12, 18
[129] Maragaret Flynn, STM-108-11, A Way to Go report, para.10 at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Flynn%2C%20Margaret%20-%20Statement.pdf
[130] Margaret Flynn, STM-108-9, A Way to Go report, para.2, at *supra*
[131] David Bingham, STM-115-15, Exhibit DB/1, Review of Leadership and Governance, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Bingham%2C%20David%20-%20Statement.pdf
[132] *supra*
[133] Transcript of 18.06.2024, p.76
[134] David Bingham, STM-115-7, Executive Summary, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Bingham%2C%20David%20-%20Statement.pdf
[135] *supra,* para.14
[136] Cathy Jack, STM-287-19 to 20, para.63 to 66, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M09%20-%2003%20-%20Jack%2C%20Cathy%20-%20Statement%20%2824.06.14%20%29.pdf
[137] *ibid*
[138] Transcript of 18.06.2024, pgs.91, 120, 121
[139] Transcript of 29.03.2023, p.19 and p.20.
[140] See for example, Sean Holland, Transcript of 21.10.2024, p.37, 39, 65
[141] See e.g. Brendan Whittle, Transcript of 17.05.2023, p.78, L.4–17
[142] See Transcript, 14.10.24, p.159, L.18-24.
[143] See respectively, Transcript of 21.10.2024, p.16 *et seq*; Michael McBride, STM-300-4, para.7 *et seq* at, https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-08/M10%20-%2003%20-%20McBride%2C%20Michael%20%28Prof.%20Sir%29%20-%20Statement%20Only%20%2824.06.28%29.pdf; Transcript of 17.10.2024, p.29; Transcript of 09.10.2024, p.64
[144] David Bingham, STM-115-7, para.5, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-06/Bingham%2C%20David%20-%20Statement.pdf

[145] See for example Peter McNaney, Transcript of 17.10.2024, p.10 *et seq*
[146] Transcript of 15.05.2023, p.55
[147] Sean Holland, STM-297-51, para 192, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-10/M10%20-%2001%20-%20Holland%2C%20Sean%20-%20Exhibits%201-18_0_.pdf
[148] *supra*, para.186
[149] Transcript, 21.10.24, p70, line 25-29.
[150] Transcript of 23.09.2024, pgs.14-15
[151] Transcript of 15.10.2024, pgs.21-22
[152] Mairead Mitchell, STM-240-1, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-08/M07%20-%2008%20-%20Mitchell%2C%20Mairead%20-%20Statement%20%2824.04.25%29.pdf and Transcript of 16.09.2024, p.94 *et seq*
[153] Transcript of 19.09.24, p.7. See too John McCart, Transcript of 16.11.2023, p.27
[154] Transcript of 17.06.2024, p.107
[155] Cecil Worthington, STM-309-1 *et seq* at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-08/M09%20-%2007%20-%20Worthington%2C%20Cecil%20-%20Statement%20%2824.07.18%29.pdf
[156] Transcript of 17.09.24, p7, lines 1 – 6.
[157] Transcript of 14.10.2024, p.13
[158] Transcript of 14.10.2024, pgs.115-116, 120-121
[159] Transcript of 16.09.2024, pgs.12, 16
[160] Transcript of 17.10.2024, p.7
[161] Martin Dillon, STM-100-2, para.5 *et seq*, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-03/Dillon%2C%20Martin%20-%20BHSCT%20Statement.pdf

[162] Michael McBride, STM-300-1 *et seq*, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-08/M10%20-%2003%20-%20McBride%2C%20Michael%20%28Prof.%20Sir%29%20-%20Statement%20Only%20%2824.06.28%29.pdf

[163] See Mark McGuicken, STM-089-75, para.17.5, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-03/1McGuicken%2C%20Mark%20-%20Statement%20and%20index%201%20-%2089.pdf and Exhibit MMcG/172, STM-089-7119, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-03/30McGuicken%2C%20Mark%20-%20Exhibit%20172%20-%20174%20Pages%207119%20-%207303.pdf

[164] Transcript of 23.09.2024, p.75

[165] Transcript of 23.09.2024, pgs.23-24

[166] *supra*, p.24

[167] Transcript of 21.03.2023, p.42, emphasis added

[168] Transcript of 21.10.24, p.131, L.9-16.

[169] Cecil Worthington, STM-309-4, para.12, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-08/M09%20-%2007%20-%20Worthington%2C%20Cecil%20-%20Statement%20%2824.07.18%29.pdf

[170] Transcript of 16.10.2024, p.18-19

[171] Andrew McCormick (2005 – 2014), Transcript of 17.10.2024, p.150; Richard Pengelly (2014 – 2022), Transcript of 23.10.2024, pgs.35-37, p.40. See too the evidence of the Inquiry's expert Alexander Ruck Keene KC, Transcript of 20.03.2023, pgs.82 and 144-145

[172] Transcript of 19.09.2024, pgs.28-29

[173] Transcript of 25.06.2024, p.162

[174] Transcript of 16.11.2023, pgs.18-19

[175] Transcript of 23.10.2024, p.57

[176] See for example Transcript of 17.10.2024, p.112 *et seq*

[177] See para.10:28, *ibid*, emphasis added

[178] Transcript, 06.06.2022, p.33

[179] See https://www.health-ni.gov.uk/news/consultation-being-open-framework-and-duty-candour-launched#:~:text=The%20Framework%20aims%20to%20address,around%20the%20Duty%20of%20Candour.

[180] Meadhbha Monaghan, STM-207-1, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2024-05/M01%20-%2005%20-Monaghan%2C%20Meadhbha%20-%20Statement.pdf

[181] Transcript, 28.05.24, p.61 line 1 *et seq*.

[182] See recommendation no.6, of the 2014 Donaldson report, 'The Right Time, The Right Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of acre provision in Northern Ireland' at https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf See too recommendation no.1 of the 2018 O'Hara report, on the Inquiry into Hyponatraemia-related deaths at Report of the Inquiry into Hyponatraemia-related Deaths, is published at https://www.ihrdni.org/Full-Report.pdf

[183] Northern Ireland Minister aims for duty of candour at https://www.bbc.com/news/articles/c3vlnnp33wlo

[184] Transcript of 06.06.2022, p.8

[185] See Opening on behalf of AFM and SPFMAH, Transcript of 13.06.2022, p.31

[186] Transcript of 21.10.2024, p.5

[187] Chair's Statement, 13.02.2023, para.5, at https://www.mahinquiry.org.uk/files/mahinquiry/documents/2023-02/Chair%27s%20Statement%20as%20to%20the%20Evidence%20Plan%20for%202023_1.pdf