MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY 10TH MARCH 2025 - DAY 124

124

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

GWEN MALONE STENOGRAPHY SERVICES

APPEARANCES

CHAIRPERSON:	MR. TOM KARK KC
INQUIRY PANEL:	MR. TOM KARK KC - CHAIRPERSON PROF. GLYNIS MURPHY DR. ELAINE MAXWELL
COUNSEL TO THE INQUIRY:	MR. SEAN DORAN KC MS. DENISE KILEY KC MR. MARK McEVOY BL MS. SHIRLEY TANG BL MS. SOPHIE BRIGGS BL MS. RACHEL BERGIN BL
INSTRUCTED BY:	MS. STEPHANIE KENNEDY SOLICITOR TO THE INQUIRY
SECRETARY TO THE INQUIRY:	MS. JACLYN RICHARDSON
ASSISTED BY:	MR. STEVEN MONTGOMERY
FOR ACTION FOR MUCKAMORE & SOCIETY OF PARENTS AND FRIENDS OF MUCKAMORE:	MS. MONYE ANYADIKE-DANES KC MR. AIDAN MCGOWAN BL MS. AMY KINNEY BL MS. HANNAH CULLINAN BL
INSTRUCTED BY:	MS. CLAIRE MCKEEGAN MS. SOPHIE MCCLINTOCK MS. VICTORIA HADDOCK PHOENIX LAW SOLICITORS
FOR GROUP 3:	MR. CONOR MAGUIRE KC MS. VICTORIA ROSS BL
INSTRUCTED BY:	MR. TOM ANDERSON O'REILLY STEWART SOLICITORS
FOR BELFAST HEALTH & SOCIAL CARE TRUST:	MR. JOSEPH AIKEN KC MS. ANNA MCLARNON BL MS. LAURA KING BL MS. SARAH SHARMAN BL MS. SARAH MINFORD BL MS. BETH MCMULLAN BL
INSTRUCTED BY:	DIRECTORATE OF LEGAL SERVICES

FOR DEPARTMENT OF HEALTH:	MR. ANDREW MCGUINNESS BL MS. EMMA TREMLETT BL
INSTRUCTED BY:	MS. CLAIRE DEMELAS MS. TUTU OGLE DEPARTMENTAL SOLICITORS OFFICE
FOR RQIA:	MR. MICHAEL NEESON BL MR. DANIEL LYTTLE BL
INSTRUCTED BY:	DWF LAW LLP
FOR PSNI:	MR. MARK ROBINSON KC MS. EILIS LUNNY BL
INSTRUCTED BY:	DCI JILL DUFFIE

INDEX

THE INQUIRY RESUMED ON MONDAY, 10TH MARCH 2025 AS FOLLOWS:

CHAIRPERSON: Thank you. Yes. Mr. Doran.

STATEMENT OF MR. DORAN

1. Introduction

MR. DORAN: Chair and Panel members, this is the final day of the Inquiry's formal public hearings. The Inquiry hearings opened on the 6th June 2022. Prior to that, the Minister For Health had first announced the intention to hold a Public Inquiry into events at Muckamore Abbey Hospital on the 8th September 2020. The Inquiry was then formally established on the 11th October 2021. 10:03 10:04

Going back to an earlier point in time, the sequence of events that gave rise to the call for an Inquiry began in September 2017. As has been well documented, the examination of CCTV footage from the hospital prompted a major safeguarding investigation into the conduct of staff towards patients. 10:04

That investigation, which has continued to run in parallel with the Inquiry has resulted in criminal proceedings against a number of staff. Those proceedings remain to be concluded.

Those who have followed news of the events at the hospital will be aware that the criminal investigation has focused primarily on the six month period prior to September 2017, during which period the CCTV system had been operative. 10:05

When ultimately the Terms of Reference of the Inquiry came to be written, however, it was acknowledged that the examination of work and practice at the hospital needed to reach beyond that relatively short period. In fact, the Inquiry has been asked to report on and make findings on events that occurred at the hospital between the 2nd December 1999 and 14th June 2021. 10:05 10:06

The task of examining the work and practice of the hospital across that lengthy time span has been a demanding one.

Further, the range of issues that the Terms of Reference have required the Inquiry to examine is extensive. I will return to the Terms of Reference later in my closing remarks but, it is worth noting at the outset, that they have required the Inquiry to examine the operation of the hospital through a very wide lens. 10:06 10:06

The core objectives of the Inquiry focus on examination of the issue of abuse, the reasons for its occurrence

and the need to ensure that it does not recur in the future.

The proper attainment of those objectives has, however, required scrutiny of practice at multiple levels. 10:07
First, the day-to-day care of patients by staff.
Secondly, the internal management of the hospital.
Thirdly, the management of the hospital by the Trust.
Fourthly, the oversight of that management by the Department.
Fifthly, the diverse roles of many other individuals and organisations relevant to the work of the hospital, including the Regulation and Quality Improvement Authority and the Patient and Client Council.

10:07
It is often observed that no two public inquiries are the same. Each inquiry will address unique factual circumstances and will face distinct challenges in the course of its work. The possibilities are endless. An inquiry may be established to examine a single event or 10:08
a series of events. An inquiry may be established to examine the practice of a single individual or of an organisation or authority. The work of an inquiry may focus on one location or multiple locations. The nature and subject matter of the inquiry, guided by its 10:08
terms of reference, will have a bearing on the evidence available to the inquiry and also on the approach adopted by the inquiry to its work.

The reach of the present Inquiry is obviously not confined to a single incident or the work of a single individual or organisation. There is not an easily defined and self-contained body of documentation that the Inquiry has been required to examine. 10:09

Likewise, there is not a self-selecting group of witnesses from whom the Inquiry has been required to hear.

Given the lengthy time frame and the breadth of issues to be examined, the Inquiry Panel has had to make decisions about documentation to be sought and examined, the witnesses to be called and the precise lines of Inquiry to be pursued for the purpose of 10:09 fulfilling the Terms of Reference.

Critically, such determinations have been made independently. The governing objective has been to enable the Inquiry to meet the Terms of Reference and 10:09 ultimately to deliver a report that will have a meaningful impact on the lives of those affected by it.

This brings me back to the following observations that I made in my opening statement in June 2022. 10:10 "Fundamentally, the Inquiry will be concerned with people. More specifically the Inquiry will be concerned with very vulnerable people and the care of the vulnerable in a hospital setting. It will be

concerned also with those people who have a responsibility for such care, from frontline staff to the upper tiers of the health service. There will perhaps be days on which we become immersed in the mechanics of how the health system works. There may be 10:10
days on which we become immersed in the proper interpretations of rules and regulations or in the nuances of a particular policy. But at the end of such days it is to people, and in particular to the vulnerable patient, to whom we must return."
10:11

Chair, I have reflected on those remarks in preparing for this closing statement. For the last three years I have worked closely with a dedicated team of counsel, solicitors, administrators and support staff. It is 10:11
our sincere hope that the work in which we have been involved will assist the vulnerable patients of Muckamore and their families in being given the answers that they rightly deserve.

10:12

In this closing statement I am going to address a number of topics. The various headings can be listed on the screen for ease of reference. It may be helpful if I read them in for the purpose of the transcript.

1. Introduction.
2. Phases of evidence, which I will address in a moment.
3. Statistics.

4. Other documentation.
5. Patient document requests or PDRs.
6. Criminal proceedings.
7. The Panel's approach.
8. Terms of Reference.
9. The evidence as related to the Terms of Reference.
10. Reports and recommendations.
11. Acknowledgments.
12. Close.

2. Phases of Evidence

The oral evidence of the Inquiry has been given in four broad phases:

1. The patient experience.
2. The evidence modules.
3. The staff experience.
4. The organisational modules.

It is worth reflecting briefly on the objectives and methodology of each of those phases. It is, of course, also important to consider the evidence holistically. For example, hearing from patients and their relatives will have assisted the Panel's understanding of how the hospital was managed. Hearing from staff and organisational witnesses will have assisted the Panel in reaching conclusions about the patient experience. There was not a clear dividing line between the staff evidence and the organisational evidence. It is

important, therefore, not to view each phase of evidence in isolation from the others.

The first phase, the patient experience, was designed to provide patients and their families with the opportunity to bring their experience of the hospital to the attention of the Panel. The Inquiry sought to ensure that this phase captured as wide a spectrum of the patient experience as possible. The Inquiry conducted early engagement sessions to increase awareness of its work. A general invitation was issued on the Inquiry's website and through the media for anyone with experience of the hospital during the time frame of the Terms of Reference to make contact with the Inquiry. Those who responded were asked to provide a short preliminary indication of how they might be able to assist the work of the Inquiry.

The Inquiry appointed an independent firm of solicitors, Cleaver Fulton Rankin, to take statements from those witnesses who appeared to be in a position to assist the Panel in addressing the Terms of Reference. Statements were also taken by the Inquiry's own solicitor team. All of those who took statements received training in working with vulnerable witnesses. Registered intermediaries were made available to witnesses as appropriate.

When giving evidence witnesses were joined by a person

in support if they so wished. The Inquiry also had counsellors on hand at the hearings to assist witnesses if needed in this phase and indeed in all phases of the evidence.

Many of the witnesses who provided statements for this phase of the Inquiry were Core Participants, whether from Action for Muckamore, the Society of Parents and Friends of Muckamore or from the third patient grouping not affiliated to either AFM or SPFM. There were also many others in this phase who were not represented and who had no ongoing role within the Inquiry but who, nonetheless, made important contributions to the Inquiry in their role as witnesses.

I will provide some statistics on witnesses who gave evidence within the various phases in due course.

It can confidently be stated, considering the oral and written evidence provided by patients and on behalf of patients in its totality, that the Inquiry has received a significant body of evidence of the patient experience at the hospital. This evidence has extended across the hospital site and across the time span of the Terms of Reference.

Prior to completion of the patient experience evidence in 2023, the Inquiry shifted its focus to the second phase of evidence. This comprised a series of specific

evidence modules. The modules where as follows:

1. Bamford and mental health law in Northern Ireland.
2. Health care structures and governance.
3. Policy and procedure.
4. Staffing. 10:17
5. Regulation and other agencies.
6. MAH reports and responses.

Each module addressed a number of subtopics which are set out on the Inquiry's website. The broad objective 10:18 of the evidence modules was to provide the Panel with information on the legal, organisational and policy background within which the hospital had been managed during the time frame of the Terms of Reference. Consideration of the adequacy and effectiveness of the 10:18 various systems and processes in place at the relevant time was largely reserved until the later organisational modules which I shall outline in a moment.

10:18

The approach adopted to obtaining evidence for this phase was a more targeted one. Suitable individuals within the relevant organisations and authorities were identified and asked to address specific matters within their areas of responsibility. The Inquiry also heard 10:19 in the first module from experts who gave presentations on the Bamford Review of Mental Health and Learning Disability in Northern Ireland and on the governing legal provisions in this jurisdiction.

The evidence presented in this phase was extensive. In addition to the oral evidence of witnesses, the voluminous exhibits to many of the statements provided the Panel with the key documentation relating to law and policy within the field of learning disability, the organisation and management of the hospital and the various structures and processes that are relevant to the Inquiry's work. 10:19

It is worth noting that the evidence relating to parts of Evidence Module 6, MAH reports and responses, was deferred until a later stage of the Inquiry and was ultimately heard in June 2024. This enabled the Inquiry to plan and to deliver an in-depth analysis of the Ennis Investigation and its outworking, the Leadership and Governance Review and other reports relating to the hospital. 10:20

The Panel will recall that the Ennis Investigation initially arose from allegations made by a care assistant employed by an independent care provider about the conduct of certain staff towards patients on Ennis Ward in November 2012. The allegations prompted a lengthy vulnerable adult safeguarding procedure resulting in a report in October 2013. The investigation was conducted in parallel with a criminal investigation under the Joint Protocol. There were subsequent criminal proceedings against two staff 10:20

members. One of them was acquitted. The assault conviction of the other was overturned on appeal. There was also a disciplinary investigation that did not ultimately result in disciplinary proceedings being taken against the staff members concerned. 10:21

The Ennis process gave rise to a number of questions including, first, whether the evidence considered in the course of that investigation was possibly indicative of a wider culture of abuse within the hospital. Secondly, given the nature of the allegations, whether the response at the time was sufficiently far reaching and robust. Thirdly, whether this was a missed opportunity to detect and to address at an earlier stage the issues that gave rise to the establishment of the present Inquiry. 10:21 10:22

The Inquiry received extensive oral and written evidence from witnesses who had been centrally involved in that earlier investigation. It is hoped that the evidence of those witnesses, as well as the evidence the Inquiry has heard about other relevant reports such as the Way to Go Report that was completed in 2018, will assist the Panel in addressing the much broader issues that are contained within this Inquiry's Terms of Reference. 10:22 10:22

The third phase of the Inquiry's hearings which commenced in November 2023, was devoted to the evidence

of staff at the hospital. As with the patient experience evidence, the Inquiry made every effort to ensure that the evidence was widely representative of experience at the hospital. This included further communications through the media and engagement sessions with staff to explain the Inquiry's work. The Inquiry also appointed an independent firm, Napier Solicitors, to provide independent advice to staff who preferred not to use the Trust solicitors. 10:23

Insofar as was possible the Inquiry sought to hear from witnesses from the various categories and levels of staff who had worked at Muckamore. Again, insofar as was possible the Inquiry sought to receive evidence of experience on the different wards and of experience extending across the time frame of the Terms of Reference. 10:24

Significantly, as emphasised from the very early days of the Inquiry's work, it was important to hear of positive experience as well as negative experience, good practice as well as bad. 10:24

There were some constraints on what the Inquiry could realistically achieve during the public hearings in this phase. As we are all aware, the Inquiry is running in parallel with live criminal proceedings. I will say more in due course about the Memorandum of Understanding that was agreed with the Police Service 10:24

of Northern Ireland and the Public Prosecution Service.

The Inquiry was conscious at all times of the need to avoid causing any impediment or prejudice to the ongoing criminal proceedings. Resort to restrictions on the wider publication of evidence beyond Core Participants, was more frequently necessary in this phase of the evidence than in others. Notwithstanding those constraints, however, the Inquiry has acquired a broad range of written and oral evidence relating to the staff experience at the hospital. This evidence extends from the late 1990s right through to the recent past in keeping with the time frame of the Terms of Reference.

10:25

10:25

The fourth and final phase of evidence, which was heard between May and October 2024, comprised a series of ten organisational modules.

1. Patient advocacy and representation.
2. Professional education.
3. Professional regulation.
4. Police role in safeguarding and responding to allegations.
5. RQIA and MHC.
6. Resettlement.
7. MAH operational management.
8. Professional organisation and oversight.
9. Trust Board.
10. Department of Health.

10:26

10:26

The evidence modules had earlier provided the Panel with evidence on the relevant systems, policies, processes and structures within which the hospital had operated. These later organisational modules enabled 10:26
the Panel to examine the adequacy and effectiveness of those arrangements. The modules included written evidence and oral evidence from a range of organisations and authorities mentioned in the Terms of Reference. 10:27

As with the evidence modules, the organisational modules required a targeted approach. Individuals invited to provide statements were asked to answer specific questions or assist with specific issues 10:27
raised by the Panel. Care was taken to identify those individuals who would be best placed to assist the Panel in addressing the Terms of Reference while appropriate flexibility was retained to obtain evidence from other individuals not initially invited to assist. 10:27
The result was a further substantial volume of evidence and accompanying material being provided to the Inquiry.

Notably, the evidence in this phase included 10:28
contributions from individuals with extensive internal management experience of the hospital. This included several witnesses who served on the hospital's core management group.

Evidence was also received from individuals with high level responsibility for the management of the hospital within the Trust, including Chairs, Chief Executives and directors of relevant areas.

The Panel also heard from individuals in senior oversight roles within the Department of Health. These included the Chief Nursing Officer, the Chief Social Worker, the Chief Medical Officer and the two Permanent Secretaries in post during the relevant time span.

Looking back at the organisational modules, they have provided the Panel with a helpful framework within which to consider the effectiveness of the structural and governance issues arising from the Terms of Reference.

As I have emphasised before, however, it is important not to view these modules in isolation from each other or from the evidence heard in the other phases.

In considering patient advocacy and representation, for example, the Panel will have been informed not only by the first organisational module, but by the evidence heard from patients and their families and by evidence heard during the evidence modules. Evidence relating to the issue of resettlement was not simply confined to the organisational module devoted to that topic, but

featured also in the earlier phases of the evidence and in the later organisational modules.

The Panel's assessment of hospital management will be informed not solely by that particular organisational module, but also by the evidence of staff and families who provided their perspectives on the running of the hospital. I could provide further examples, but the basic point is that the evidence needs to be viewed globally rather than as a series of discrete elements. 10:30

3. Statistics

Following on from this outline of the four phases of the hearings it would be helpful I think to provide some statistical information on the evidence received by the Inquiry and I've asked for the key figures to be displayed on the screen. The figures have been double checked and are hopefully correct but there might still be some minor discrepancies. 10:30 10:31

Prior to the closing statements there were 120 sitting days throughout the course of the Inquiry. The approximate percentage of overall hearing time given over to each phase was as follows: 10:31

Patient experience 30%
Evidence modules 21%
Staff 25%
Organisational modules 22%.

That allows for about 2% for opening statements and other non-evidence hearings.

63 witnesses gave evidence in the patient experience phase. 27 statements were read in. A further 16 witnesses featured in the first of two round up sessions of accounts that did not fall directly within the Inquiry's Terms of Reference or where the information provided was too limited to require oral evidence or to be read into the record. The accounts of four further patient experience witnesses were included in the later round up session towards the conclusion of the hearings. 10:32 10:32

40 witnesses gave oral evidence for the purpose of the evidence modules. That includes the two expert presentations received by the Inquiry in evidence Module 1 on the Bamford Review and Mental Health Law in Northern Ireland. 10:32

A total of 57 statements were received for the purpose of those modules. That figure includes several supplementary statements that augmented the information and material provided by witnesses in their initial statements. 10:33

40 witnesses gave oral evidence in the staff experience phase. 18 statements were either read in or extensively summarised. The accounts of a further

eight staff witnesses were dealt with in the second round up session towards the conclusion of the evidence.

38 witnesses gave oral evidence for the purpose of the organisational modules. The Inquiry received a total of 88 statements for those modules, again including several supplementary statements. 10:33

There was also a small number of statements received following the Inquiry's initial request for assistance that did not ultimately assist with the Panel's consideration of the Terms of Reference. 10:33

From those statistics it can be seen that a total of 181 witnesses gave oral evidence to the Inquiry. A further 45 statements were read for the purpose of the patient experience and staff phases. The accounts of 28 other patient experience and staff witnesses were dealt with by way of round up. In total the Inquiry received 333 statements across the breadth of the issues that will be the subject of consideration by the Panel for the purpose of addressing the Terms of Reference. 10:34 10:34

By any measure that is a substantial volume of evidence relating to direct experience of life in the hospital, the health system in which it is based and more generally, the subject of caring for vulnerable persons

with learning disabilities.

Can we return to the outline on the screen now, please.

4. Other documentation. 10:12

The majority of the documentation to be considered by the Panel has been received in the course of the four phases of evidence that I have described. It will be noted in particular that the statements for the purpose 10:35 of the evidence modules and the organisational modules have exhibited a substantial volume of materials that are of immediate relevance to the Inquiry's work. On some occasions a specific bundle of materials was prepared by the Inquiry for use in conjunction with a 10:35 witness's evidence.

In the course of its work the Inquiry has also engaged with multiple organisations and authorities to ensure that all documents that might assist the Panel in its 10:36 work have been obtained. It is fair to say that the Inquiry has cast the net very widely in this regard out of an excess of caution. The Inquiry's engagement has extended well beyond the core authorities such as the Trust, the Department and RQIA to include all sources 10:36 of material that could conceivably assist with the Inquiry's work.

Any material received has, in turn, been assessed for

the purpose of determining whether it will assist the Panel in addressing the Terms of Reference. As I have indicated, a large proportion of the material to be considered by the Panel has been channelled to the Panel and disclosed to Core Participants through the written evidence given to the Inquiry in phases one to four.

Having said that, there have been other sets of materials that the Panel has considered and that have been disclosed separately from the main body of evidence given to the Inquiry. For example, the Inquiry has compiled a full set of the MDAG minutes, the Core Group minutes, relevant extracts from delegated statutory functions reports and entries relating to Muckamore on the various levels of risk register.

The Inquiry also compiled a specific set of materials around the Ennis Investigation and its outworkings.

The assessment of materials provided to the Inquiry is now complete. If it transpires that the Panel wishes to consider any further material for the purpose of its report, such material will be disclosed to Core Participants subject to any restrictions that may be necessary. If that does occur, as you have previously stated, Chair, the Panel will permit Core Participants to make written observations on such material if they

so wish.

5. Patient document requests (PDRs)

One further category of documentation that I would like to mention specifically at this point is patient records. Many of the patients whose experiences have been recounted to the Inquiry spent very long periods in hospital, some extending to several decades. The global production of every single record relating to each patient who has featured in the Inquiry could potentially have resulted in the Inquiry becoming overwhelmed by hundreds and thousands of pages of documentation. Having regard to the subject matter of the Inquiry, the Panel wished the evidence given to the Inquiry to be led by the accounts of witnesses rather than by the production of documents. This approach had particular ramifications for the Inquiry's receipt of and reliance on patient records. You summarised the position, Chair, in an early statement of the 23rd of November 2022 in which you said as follows:

10:38
10:38
10:39
10:39

"On the question of documents I have repeatedly said that if we wait for every document or note relating to every patient involved in this Inquiry, not only would the Inquiry be very significantly delayed, but the Inquiry would be swamped with material only a fraction of which may in fact be required by the Inquiry. There is a danger of losing sight of the wood for the trees.

10:40

Some patients will have thousands of pages of notes and it would be easy to become overwhelmed with paperwork. My preferred course is to make targeted requests to the Trust and to other organisations once we have analysed the evidence received by the Inquiry." 10:40

This decision to make targeted rather than blanket requests for patient records resulted in the Inquiry making specific requests for documentation in respect of 34 patients. These requests were given the 10:40 convenient label of Patient Document Requests or PDRs for short.

For the most part the material was sought from the Belfast Trust, although in some cases there were 10:41 additional requests for material from other Trusts where appropriate, and from organisations such as the RQIA and the PCC.

The PDRs were not simply requests for all existing 10:41 records relating to the care of particular patients in the hospital. Rather, the requests were typically confined to particular issues and/or periods of time in the patient's stay at the hospital about which the Panel wished to obtain further information. That 10:41 information would augment the evidence that had been given about those patients in the course of the written and oral evidence.

This targeted approach has enabled the Panel to conduct

a focused study of issues arising from the care of a number of patients prompted by the evidence heard in the patient experience phase.

It will ultimately be a matter for the Panel as to how the Panel may wish to deploy that material in its ultimate report. 10:42

It is worth noting in passing that there was an unsuccessful Judicial Review challenge to the process whereby the Inquiry proposed to obtain records by way of PDRs. That challenge was initiated by the mother of one of the patients in respect of whom a patient document request had been made. In his judgment in that case, JR276, [2023] NIKB107, the judge, Mr Justice Schofield made the following observations concerning the requirements of Article 8 of the European Convention on Human Rights in this context. And he made this observation at paragraph 134 of the judgment: 10:42 10:42

"The limit of what Article 8 requires in circumstances such as these is that a patient whose medical notes and records are obtained by a public Inquiry is informed of that as soon as practicable after the records have been received. In this way no person will be ignorant of such a disclosure having been made. Where the Inquiry has obtained patient records under a patient document request, it has informed the patient's family and legal representatives accordingly. The Inquiry has also 10:43

provided a broad indication of the categories of material received and the time frame to which that material relates. The Panel may wish to engage further with patients' families about any detail to be included in the report based on these records but that will be a matter for the Panel to consider as it proceeds with its work." 10:44

6. Criminal proceedings.

Having outlined the Inquiry's four phases of evidence and approach to documentation, I now wish to turn briefly to consider the measures adopted by the Inquiry to avoid the risk of prejudice to the ongoing criminal proceedings. 10:44

The criminal investigation arising from events at the hospital captured on CCTV in 2017 was well under way when the Minister of Health announced the establishment of this Inquiry on the 8th September 2020. The decision to prosecute a number of individuals who are currently before the Crown Court was made in or around April 2021. That was over a year before the Inquiry hearings started. 10:44

10:45

The investigation has continued and further prosecution decisions have been made during the period in which the Inquiry has been sitting. No trial date has yet been fixed. The outworking of this exceptional and large

scale criminal process remains incomplete.

The challenges that would be presented to the Inquiry in these circumstances were acknowledged from the outset of the Inquiry's work. Prior to the oral hearings, the Inquiry consulted with the Police Service of Northern Ireland and the Public Prosecution Service for Northern Ireland with a view to addressing those challenges. The result was the agreement of a Memorandum of Understanding between the Chair of the Inquiry and those two authorities on the 9th of March 2022. 10:45 10:46

The MOU has been subject to review and monitoring in the course of the Inquiry. A revised version was issued on the 13th December 2022. The third and current version was issued on the 5th of October 2023. 10:46

The objective of the MOU, as stated in paragraph 7 of the document, was: 10:46

"To state the shared understanding of how the Inquiry, the PSNI and the PPS will discharge their respective statutory responsibilities as the Inquiry, the investigation and prosecutions proceed." 10:47

Throughout the duration of the hearings the Inquiry team has liaised regularly with PSNI and PPS and has sought to ensure, in accordance with the MOU, that the

procedure and conduct of the Inquiry has respected the integrity of the investigation and prosecutions while continuing to address the Terms of Reference.

Importantly however, as acknowledged in the MOU, when restrictions on the publication of evidence or material had been imposed, such restrictions have had to be justified with reference to Section 19 of the Inquiries Act 2005. Therefore, while appropriate measures have been taken to protect against the risk of prejudice to the criminal proceedings, those measures have involved the least possible restriction on public access to the proceedings in keeping with the letter and the spirit of Section 19 of the 2005 Act. 10:47 10:48

It is worth recalling that the ability of the Inquiry to function in parallel with the ongoing criminal proceedings was called into question at an early stage of the hearings. This occurred in judicial review proceedings taken by one of the defendants in the first group of prosecutions. The case is titled: "In the Matter of an Application by JR222." The applicant in that case challenged the Minister's refusal to suspend the Inquiry. The applicant's core argument was that the continued reporting of the Inquiry proceedings would prevent the applicant having a fair trial. The challenge was dismissed by Mr Justice Colton in the High Court. For the record the citation is [2022] NI KB03. 10:48 10:49

Further appeals to the Court of Appeal and Supreme Court were also unsuccessful. Those appeals were based solely on the interpretation of Section 13.1 of the Act which governs the minister's powers to suspend an Inquiry. The citations for the Court of Appeal and Supreme Court judgments are [2022] NICA 57 and [2024] UK SC35 respectively. 10:49

I am not going to revisit the details of the challenge. It is however, important to note that the Inquiry's approach to addressing the risk of prejudice has been before the courts at all levels. 10:49

Significantly, the central question of principle as to whether the Inquiry and the ongoing criminal proceedings could co-exist without compromising the applicant's fair trial rights was resolved in the Inquiry's favour by the High Court. That fundamental determination of principle was not subject to challenge in any of the subsequent appeals. Both the Court of Appeal and the Supreme Court did, however, observe that the Chair of an Inquiry is well placed to manage issues arising at the interface with criminal proceedings. The Court of Appeal said, at paragraph 42 of its judgment: 10:50 10:50 10:51

"We are not concerned with the decision to proceed with an Inquiry in the midst of criminal proceedings.

Rather, the Inquiry having started, the question is whether it should now be suspended given ongoing criminal proceedings which affect the appellant and others. This is a challenging issue for any public Inquiry given the twin aims to obtain best evidence and protect the rights of individuals charged. However, the independent Inquiry Chair is undoubtedly well placed to assess the issue on an ongoing basis." 10:51

The Minister is at a remove and so whilst he has a power to suspend an inquiry it is on particular terms as we shall see. Later at paragraph 54 the Court observed that: 10:51

"There is an obvious and delicate equilibrium to a public Inquiry proceeding whilst criminal charges are also progressed, this is something that must be managed by the Inquiry Chair and reviewed on an ongoing basis." 10:51

The Supreme Court noted at paragraph 32 of its judgment that the dialogue with the Inquiry about the ongoing criminal proceedings: 10:52

"Enables the Inquiry to keep under constant review the question of the protective measures to preserve the integrity of the criminal investigation and proceedings. Based on further information provided by the PPS and the PSNI, the Inquiry can consider exercising its powers under s.17 of the act to give 10:52

directions as to procedures and under s. 19 of the Act to make restriction orders."

The Supreme Court went on to observe at paragraph 33 that the MOU provides for ongoing co-operation between the three parties and that the measures taken by the Inquiry were not static and could be adapted. The Court also referred at paragraph 34 to the importance of the basic principles within the MOU. The Court rehearsed some of the provisions of the MOU and outlined other measures of relevance to the criminal process, including the undertaking by the Director of Public Prosecutions, the Chair's restrictions orders, the strict confidentiality undertakings signed by Core Participants, and the representation of PSNI by senior counsel at the Inquiry. 10:53 10:53 10:53

The Supreme Court then observed at paragraph 43:

"All these measures which I have summarised were arrived at after much thought by the Chair and were devised in consultation with all interested parties. They are also subject to review and adaptation by the Chair as evidence is heard or as a result of developments in relation to the criminal investigations or proceedings." 10:53 10:54

Significantly, therefore, the measures adopted by the Inquiry to guard against prejudice were not only

judicially endorsed by the High Court but were also noted with approval by the appellate courts.

The courts also referred to the dynamic nature of the various arrangements that were in place. You, Chair, have remained alive to the need to adapt those arrangements as appropriate as the Inquiry has progressed, hence the revised versions of the MOU, the various restriction orders that have been made and the receipt of ongoing information from the PSNI and the PPS as to the progress of the investigation and the prosecutions. 10:54 10:55

Finally in this regard, the Panel will continue to be mindful of the basic principles of the MOU as it moves towards production of the report. Importantly, however, this will not inhibit the Panel in making the findings and recommendations that it regards as appropriate. 10:55

In summary, the Inquiry has operated and will continue to operate with sensitivity to the live nature of criminal proceedings that may conceivably extend for some time beyond the life of the Inquiry. 10:55

Chair, I wonder if this might be a suitable moment to take a short break.

CHAIRPERSON: According to your list you are about half way through, so that's perfect timing, so we'll take 15

minute break, thank you very much.

AFTER A SHORT BREAK THE INQUIRY RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you. Mr. Doran. 11:14

MR. DORAN: I now wish to return very briefly to how the Panel has approached its work.

7. The Panel's approach. 10:12

While the Inquiry's Act 2005 and the Inquiry Rules 2006 provide the governing legal framework, there is no fixed template to which an Inquiry must adhere for the purpose of achieving its objectives. It is trite to 11:15
say that an Inquiry must act entirely independently. Importantly, s.17 of the Act reinforces the Inquiry's independence by affording the Chair a wide discretion as to how the Inquiry is to be conducted.
S.17(1) the Act provides that subject to any provision 11:15
of the Act or the rules the procedure and conduct of an Inquiry are such as the Chair may direct. When making any decision as to procedure and conduct the Chair is required by s.17(3) to act with fairness and with regard also to the need to avoid any unnecessary cost. 11:16

Core Participants have a central role to play in the Inquiry. They have assisted the Inquiry in multiple ways, for example, through witness evidence, through

the provision of documents, through suggesting questions to be asked of witnesses and through suggesting lines of inquiry.

The Inquiry Rules permit applications to be made to question witnesses in certain circumstances. The Rules also provide Core Participants with an entitlement to make opening and closing statements. The Panel heard the closing statements of several Core Participants last week. 11:16

Ultimately, however, when it comes to making a call on how the Inquiry is going to approach its work, that responsibility falls on the Chair. As I have said, this reinforces the independence of the Inquiry. 11:17
It is not surprising that there may be occasions on which the Chair's procedural determinations are at odds with the view of one Core Participant or a number of Core Participants as to how things ought to be done. It is vital in terms of securing public confidence in 11:17
an Inquiry that the Chair should be in a position to resist, where appropriate, proposals to depart from the procedure and conduct that the Chair has chosen to adopt.

These observations are of particular significance when applied to representations by a public authority whose conduct is under scrutiny as to how an Inquiry should conduct its business.

The independence of the Inquiry is of obvious importance in this context. It would be quite wrong for the Trust or any other public authority to be permitted to adopt their own procedural preferences in the context of the Inquiry. Likewise, it would be quite wrong if the Trust or any other public authority were permitted to direct the lines of Inquiry to be undertaken by the Panel. It is for the Chair and the Panel to determine those matters. 11:18

There have been several occasions on which you, Chair, have had to adopt procedures that you regarded as most suitable to advance the work of the Inquiry. There were three particularly notable examples. First, I have already referred to the Inquiry's targeted approach to obtaining patient records by means of the patient document requests or PDRs. As you explained Chair, this approach was guided by the objective of ensuring that the work of the Inquiry would not be stifled or overwhelmed by documentation that would not ultimately assist the Panel in addressing the Terms of Reference. 11:18 11:19

The second notable example arose from the taking of statements. As I have mentioned, Chair, at an early stage of the Inquiry you appointed an independent firm of solicitors to take statements from witnesses in the patient experience and staff phases of the Inquiry. 11:19

Ultimately all statements in the patient experience and staff phases were taken either by that firm or by the Inquiry's own team of solicitors.

Thirdly a decision had to be made on how specific criticisms and allegations that had arisen in the patient experience evidence ought to be dealt with when staff gave evidence. You, Chair, addressed this matter in a statement of the 2nd November 2023. In that statement you explained that the Inquiry did not intend generally to put to staff witnesses individual criticism and allegations arising out of specific factual scenarios that had arisen in the patient experience evidence. Rather, the approach of the Inquiry would, where appropriate, be to ask staff to respond to generic themes and lines of criticism that were relevant to their particular area of work. There would be exceptions to this approach, as you explained in the statement. 11:20 11:20 11:20

There had been some instances in which very serious criticism or allegations of a personal, specific and direct nature had been made against named members of staff from whom the Panel wished to have a statement. The Panel indicated that in limited circumstances such as these, the criticism or allegations may, where appropriate, be put to the witness. In the event, there were a small number of witnesses to whom this specific procedure was applied. 11:21

In addition to those important procedural determinations, Chair, you and the Panel also had to make decisions as to the written evidence to be obtained and the witnesses to be called. All such decisions in each of the phases of evidence were made with reference to the overriding objective of assisting with the Terms of Reference. The approach of the Panel with respect to such decisions was very recently endorsed by Mr Justice Humphries in the High Court. For the record the reference for that judgment is 2024 NI KB107. 11:21 11:22

Core Participants did not always agree with the Inquiry's approach to matters of evidence and procedure. Throughout the Inquiry, Core Participants properly made representations as to their preferred approach to the various matters that I have outlined. Importantly, however, it was for you, Chair, and the Panel to take an independent course and to adopt the methodology that you regarded as best suited to achieve the objectives as set out in the Terms of Reference. 11:22 11:22

8. Terms of reference

11:23

I now want to return to the Terms of Reference which, of course, set the agenda for the work of the Inquiry.

Section 5 subsection 5 of the Inquiries Act 2005

provides:

"Functions conferred by this act on an Inquiry Panel or a member of an Inquiry Panel are exercisable only within the Inquiry's Terms of Reference." 11:23

The word "only" is significant. The legislation imposes this very specific restriction on what the Panel can do. I do not propose to go through all of the Terms of Reference in the same degree of detail as 11:23 in my opening statement. The issue that I do wish to address, however, is how the evidence received by the Inquiry will enable the Panel to examine and to report on the matters that the Terms of Reference have presented for its consideration. 11:24

The core objectives are set out in paragraph one. The time frame within which the Panel is to report and make findings is specified in paragraph two. That is, as I have said, between the 2nd December 1999 and the 14th 11:24 June 2021.

Paragraph three provides the Inquiry with discretion to receive evidence outside that time frame where it will assist the Inquiry in examining, understanding and 11:24 reporting on matters within the time frame.
The next parts of the Terms of Reference from paragraph 4 to paragraph 19, set out in considerable detail a number of issues that the Panel is asked to examine.

These paragraphs present eight separate issues, although all of those issues are closely interrelated and hark back to the core objectives.

The eight issues are as follows: First, paragraphs 4 to 8 require the Inquiry to examine the nature and extent of abuse of patients at the hospital. 11:25

Paragraph 5 provides a non-exhaustive list of what the term "abuse" may include. The non-exhaustive nature of the list is important. For example, the Panel would be free to consider the question of whether what occurred at the hospital constituted institutional abuse, even though that term is not specified in paragraph 5. 11:25

Paragraph 6 makes reference to staff and persons with oversight and leadership responsibility at all levels.

Paragraph 7 requires consideration of the adherence by those at all levels to the regulatory and statutory framework. 11:26

Paragraph 8 requires consideration of the primary and secondary causes of abuse and invites the Panel to consider whether the abuse resulted from systemic failings within the hospital or the wider healthcare system. 11:26

Secondly, paragraph 9 requires an examination of the

policies and practices relating to recruitment, retention, training and support of staff and management at all levels within the hospital and, where necessary, within other facilities offering comparable services.

11:26

Thirdly, paragraphs 10 to 13 relate to the identification of and response to concerns about treatment of patients at the hospital. Those paragraphs encompass the methods whereby concerns could be communicated, how staff and others in positions of 11:27
responsibility responded to those concerns and also the response of other agencies when concerns were reported to them. Importantly, paragraph 12 makes reference to the question of whether there were failings in the early identification, investigation and resolution of 11:27
issues raised about the treatment of patients.

Fourthly, paragraph 14 provides in very brief terms that the Inquiry will examine the effects of installment, operation and use of CCTV at the hospital. 11:27

Fifthly, paragraph 15 refers to the adequacy of safeguards, mechanisms and policies in place to ensure that the patients were protected from other patients within the hospital. 11:28

Sixthly, paragraph 16 requires the Inquiry to examine the adequacy and workings of the policy and process of discharge and resettlement of patients at the hospital.

Seventhly paragraph 17 requires consideration of the adequacy of the resourcing of staffing and care.

Eighthly, and finally, paragraphs 18 and 19 address the adequacy of the legal and regulatory framework. 11:28

For completeness, paragraphs 20 to 22 deal with matters of practice and procedure, I don't need to say any more about those paragraphs for present purposes.

Finally paragraphs 23 to 25 make provision for the report and recommendations and I will return to those paragraphs shortly.

9. The evidence as related to the Terms of Reference. 10:12

Before that I would like to provide an overview of how the evidence the Panel has received will assist in addressing the eight areas for examination within the Terms of Reference. It is important again to emphasise 11:29 the need for the evidence to be considered in the round. While some issues have been addressed discretely through a limited number of witnesses, a consideration of other issues has extended across the four phases of the evidence. This applies particularly 11:29 to the primary issue of the nature and extent of abuse and its causes. Examination of that issue has rightly been central to the Inquiry hearings.

The Panel has heard extensive evidence from the families of patients and from some patients at the hospital. It has also heard from staff who worked within the hospital at all levels. Through the evidence modules the Panel has gained an understanding of the wider structures within which the hospital has operated. The later modules have enabled the Panel to examine critically the broader organisational setting within which the events leading to this Inquiry occurred. 11:30

It should be added that the Panel has had the opportunity to view CCTV footage which forms the basis of the ongoing criminal proceedings.

The Panel has also been informed of the progress of those proceedings and of prosecutorial decisions that will result in further individuals appearing before the courts arising from events at the hospital.

Further, the Panel has had access to the database on which the Belfast Trust recorded incidents viewed on CCTV in the course of the Joint Protocol investigation. The Inquiry has provided Core Participants with the key statistical data that it extracted from that database. 11:31

In the course of its work the Inquiry has also considered historical complaints and concerns raised about the conduct of staff and how those have been

addressed. As I have indicated, the Inquiry spent considerable time examining the Ennis allegations and subsequent investigation. The Inquiry has also had the benefit of examining other significant reports relating to the hospital and of hearing evidence from the authors of such reports. 11:31

Regarding the second issue relating to recruitment, retention, training and support, the Panel's attention is drawn in particular to the evidence from Evidence Module 4 on staffing, organisational Module 2 on professional education and also the later organisational modules. 11:32

In addition to those modules, of course, the Panel heard many members of staff themselves speak of their own experience of education and employment at the hospital. 11:32

The third issue of identifying and responding to concerns has been examined in all phases of the evidence. The channels for raising concerns were the subject of focused attention in evidence Module 3 on policy and procedure. So too were the mechanisms for identifying and responding to concerns. 11:32

Evidence Module 5 focused on the roles and responsibilities of the Regulation and Quality Improvement Authority and its predecessor body, the

Mental Health Commission, as well as the Health and Safety Executive for Northern Ireland and the Patient and Client Council.

Organisation Module 1 was specifically dedicated to examining the role and effectiveness of bodies and organisations with responsibility for representing the interests of patients. 11:33

Organisational Module 3 looked at professional regulation, specifically the responsibilities of the Nursing and Midwifery Council and the General Medical Council in dealing with referrals. 11:33

Organisational Module 4 examined the police role in Joint Protocol investigations. While organisational Module 5 considered the effectiveness of RQIA inspection and the prior role of the MHC. 11:33

The fourth issue, the effects of installment, operation and use of CCTV has been examined periodically in the course of the evidence sessions, particularly in the course of the staff phase. 11:33

In written and oral evidence several staff witnesses addressed the question of whether in their experience the instalment and use of CCTV had impacted on conduct in the wards. 11:34

An assessment of the effect of installment, operation and use of CCTV will be particularly challenging. What was seen on CCTV provided the impetus for this Inquiry. The Panel will be aware, however, that during the key period in 2017 it was not known that the CCTV system was operative. The Panel will be conscious of those exceptional circumstances when arriving at any conclusions in respect of paragraph 14 of the Terms of Reference. 11:34

The fifth issue relating to safeguards, mechanisms and policies to deal with abuse or disturbing behaviours by other patients has been considered throughout the evidence in parallel with the primary focus of the Inquiry's work on abuse by staff. 11:35

The sixth issue, discharge and resettlement, was the subject of a specific module, organisational Module 6. That module included contributions from several agencies involved in the process of resettlement. In that module the Panel also heard from the authors of the recent report of the independent review of the learning disability resettlement programme in Northern Ireland which was published in 2022. 11:35

Importantly, as I suggested earlier, the issue of resettlement provides an illustration of the need to consider the evidence holistically as the matter has featured in evidence throughout the hearings. The

Panel heard from many witnesses in the early evidence sessions of recounted both positive and negative experiences of the discharge and resettlement of their relatives from the hospital. Staff witnesses also spoke of their experiences of working with patients awaiting discharge. 11:36

Resettlement policies were considered in evidence Module 3. Significantly, the matter was also addressed as appropriate in written and oral evidence in the later organisational modules involving hospital management, the Trust Board and the Department of Health. 11:36

In addition to the evidence that the Panel has received for the purpose of addressing paragraph 16 of the Terms of Reference, the Panel has also indicated that it wishes to receive further information about recent and ongoing experiences of resettlement. The purpose of this exercise will be to assist with its recommendations and I shall say more about that when I come on to deal with recommendations later in this statement. 11:36 11:37

The seventh issue relating to resourcing of staffing and care has also been the subject of consideration across the various phases of evidence. The resource issue was specifically raised the Departmental evidence for the purpose of evidence Module 2 and organisational 11:37

Module 10. The first topic in the former module was the budget for mental health and Learning Disability Services. One of the matters explored in the latter module related to the arrangements in place at departmental level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix and thereby to ensure safe care at the hospital. 11:38

The Panel's assessment of the adequacy of resourcing will also, of course, be informed by the evidence of those who have had direct experience of the hospital, whether as staff, patients or relatives of patients. 11:38

The eighth and final issue, the legal and regulatory framework and their adequacy, received extensive consideration throughout the evidence. In particular, evidence Module 1, Bamford and Mental Health Law in Northern Ireland, Module 2, healthcare structures and governance, and Module 5, regulation and other agencies, provided the Panel with the key materials required to understand the legal and regulatory framework. 11:38 11:39

The adequacy of the governing framework fell to be considered throughout the organisational modules. Specific attention is drawn to organisational Module 3 professional regulation, and organisational Module 8, professional organisation and oversight. 11:39

Critically the question of the adequacy of the governing framework to prevent abuse relates back to one of the core objectives, that is to determine why abuse happened and the range of circumstances that allowed it to happen. 11:39

Chair, Panel, that completes my survey of the issues that the Panel is required to examine in accordance with the Terms of Reference. 11:40

The references that I have made to the evidence should not be regarded as a comprehensive statement of how the evidence received matches up to the Terms of Reference. The multiple issues that the Inquiry has been asked to consider frequently overlap and it would be unwise to categorise the evidence too rigidly. I hope, however, that this brief survey will have provided some assistance to the Panel in its work towards production of the report. 11:40 11:40

10. Report and recommendations

The final section of the Terms of Reference relates to the report and recommendations. Paragraph 23 provides that the Inquiry will submit its report to the Minister of Health. Paragraph 23 also provides that the Inquiry may make findings on matters within the Terms of Reference as outlined above, including the issue of 11:40

abuse and whether such abuse resulted from systemic failings.

Paragraph 24 states:

"Having regard to and dependent on those findings the Inquiry will make recommendations in respect of the following seven matters:
(a) The core objective of ensuring that any such abuse and any such failings do not recur at MAH or at any other facility providing similar services in Northern Ireland.
(b) Improvement of the training of staff and management at MAH and comparable facilities.
(c) Improvement of management, policies, systems and processes within MAH including those relating to whistleblowing and corporate governance.
(d) improvement of competence, quality and internal governance of the board of such hospitals.
(e) To the extent that it is necessary and appropriate, the role of wider adult social care services and the relevant health and social care bodies, including but not limited to the health and social care trusts, the Health and Social Care Board, the Public Health Agency and the Department in ensuring the safety of patients and best practice in service delivery at MAH and comparable facilities.
(f) The legal and regulatory framework and related matters.

(g) The requirement or desirability of the provision of redress to meet the particular needs of victims of abuse within MAH."

Finally, paragraph 25 provides that: 11:43

"The Inquiry Chair may, if necessary and appropriate, issue an interim report or reports with recommendations."

Chair, you have not regarded it as necessary and appropriate to date to issue such a report.

Before moving on from the report and recommendations as prescribed in the Terms of Reference, I want to draw 11:43
attention to Section 24, subsection 1 of the Inquiries Act 2005 and to return briefly to the topic of resettlement. Subsection 1 reads as follows:

"The chairman of an inquiry must deliver a report to 11:43
the Minister setting out the facts determined by the Inquiry Panel, the recommendations of the Panel where the Terms of Reference required it to make recommendations. The report may also contain anything else that the Panel considers to be relevant to the 11:44
Terms of Reference including any recommendations the Panel sees fit to make despite not being required do so by the Terms of Reference."

This provision requires the Chair to deliver a report to the Minister setting out the facts determined by the Panel as well as the recommendations where the Terms of Reference required the making of recommendations.

11:44

As I have indicated, the making of recommendations is required by paragraph 24 of this Inquiry's Terms of Reference. Importantly, this provision also affords the Panel latitude to include in the report anything else that it considers to be relevant to the Terms of Reference. This may include any recommendations the Panel sees fit to make, even though not required to do so. The Terms of Reference of this Inquiry do not specifically require the Panel to make recommendations on the matter of resettlement.

11:44

11:45

The issue of resettlement does, however, continue to give rise to real concerns for many families and patients. Core Participant families have properly brought those concerns to the attention of the Panel. Mindful of those concerns, the Panel has indicated that it wishes to receive further information relating to recent and ongoing experiences of resettlement for the purpose of informing its recommendations. This information is not sought for the purpose of the Panel's examination of discharge and resettlement within the time frame of the Terms of Reference as required by paragraph 16. The Panel has received evidence for that purpose through the four phases of

11:45

11:46

the hearings as I have already outlined.

The Panel intends to receive further information by way of information sessions. Its planned approach was issued to Core Participant patient families in the first instance for comments. Those comments have been received. The Panel will issue details of how and when the sessions will be conducted when it has settled on the format to be adopted. All Core Participants will be kept informed as appropriate. 11:46

It should be noted that the sessions will be open not only to Core Participants and to witnesses who have given evidence to the Inquiry, but also to others who may be in a position to assist the Panel with the issue of resettlement from Muckamore. 11:47

The resettlement sessions will be conducted as a discrete exercise designed to assist the Panel with its recommendations. Aside from this exercise, the Panel will, of course, be proceeding with the preparation of its report. 11:47

One further procedure that it would be appropriate to mention briefly at this stage arises from Rules 13 to 16 of the Inquiry Rules 2006. Those provisions govern the issue of warning letters. Importantly, the Panel must not include any explicit or significant criticism of a person in the report unless the person has been 11:47

issued with a warning letter by the Chair and afforded a reasonable opportunity to respond.

You Chair, and the Panel, will of course have regard to those Rules at the appropriate time prior to the report being finalised. 11:48

10. Acknowledgements

Before I finish I would like to say a few words to acknowledge the many and diverse contributions that have enabled the Inquiry to advance to this stage. 11:48

Sadly in the period since the oral hearings commenced in June 2022, some who have contributed directly to the Inquiry's work have passed away. 11:48

Eileen McLarnon was a nurse at the hospital from 1972 until her retirement in 2016. She provided the Inquiry with a detailed statement which was read to the Panel on Tuesday the 6th February 2024. Eileen passed away on the 12th April 2024. 11:49

Geraldine O'Hagan was the Family Liaison Social Worker for a number of families of patients at the hospital. She provided unwavering support to those families prior to and in the course of the Inquiry. She attended the Inquiry on the 15th May 2024 and gave her evidence with the support of her son, Josh. Geraldine passed away on 11:49

the 10th June 2024.

The fortitude that Geraldine displayed in assisting the Panel in the face of serious illness will surely live long in the memory of all of us involved in this Inquiry. 11:50

The Inquiry team wishes to thank the legal and support teams for all Core Participants and others who have contributed to the work of the Inquiry. 11:50

The work of a public Inquiry requires a significant commitment over a lengthy period. We wish to acknowledge their cooperation in the course of the Inquiry and the work that they have done on behalf of their clients to assist the work of the Inquiry. 11:50

It is also important to mention those working behind the scenes, both for Core Participants and others, who have assisted with providing materials and information to the Inquiry. Their work is not as visible as that of the legal representatives, but it is critically important in enabling the Inquiry to achieve its objectives. 11:50

11:51

The Inquiry itself has required ongoing support and assistance from many quarters including the statement takers, those who have provided Witness Support and those who have assisted with media communications.

Thanks are also due to the stenographers, the technical team and the Inquiry's security staff. They have all worked very hard to ensure the smooth and effective running of the proceedings. 11:51

I am not going to name names for fear of missing someone out, but all can be assured that their efforts have been much appreciated. 11:52

I said that I wouldn't name names but I may make an exception in the case of Davy and Rab. They have welcomed all visitors to the Inquiry day and daily over the course of the hearings. They were with the Inquiry team even before we moved to these premises at the Corn Exchange. They've managed at all times to keep things on an even keel, even during the very intense periods of the Inquiry's work. 11:52

On behalf of the counsel team I want to thank Jaclyn Richardson, the secretary to the Inquiry, and Stephanie Kennedy the solicitor to the Inquiry and her predecessor, Lorraine Keown. They and all the members of their administrative and solicitor teams have worked closely with counsel throughout the proceedings and have supported us tirelessly in the various aspects of our work. 11:52

I am also, of course, very much indebted to my own counsel team for their dedication and commitment

throughout the Inquiry.

As the formal hearings come to a close, counsel also wish to acknowledge the contribution of the witnesses to the Inquiry. As I have said, the Inquiry has heard from a wide range of witnesses including patients and their families, staff who have worked at the hospital and individuals working in positions at many levels with direct and indirect responsibility for the operation of the hospital. 11:53

Their accounts have provided the Panel with the primary source of information that will assist the Panel in preparing its report.

11:53

Chair and Panel, it is most important to acknowledge the contribution of patients and their families to the work of this Inquiry. It has been a privilege for me and for my team to have met many of them over the last three years. The pain that they have endured on 11:54 becoming aware of what occurred at the hospital is, quite frankly, beyond our comprehension. We wish to acknowledge their courage in sharing deeply personal experiences with the Inquiry. They have provided insights of immeasurable value to the important work in 11:54 which the Inquiry is engaged. They have done so selflessly. Importantly, they have done so for the benefit of the wider public interest that this Inquiry was established to serve.

Chair, I began my opening in June 2022 by welcoming you and the Panel to Belfast on behalf of all representatives. As the various closing statements have illustrated, much has been achieved in the intervening period. A substantial body of evidence has been presented to you for the purpose of your consideration of the Terms of Reference.

I now close by wishing you and the Panel well in your remaining work towards production of the report.

CLOSING STATEMENT - THE CHAIRPERSON

CHAIRPERSON: Thank you, Mr. Doran, thank you very much indeed.

This is the last formal hearing day of this public Inquiry and I want to make a few remarks about that and these remarks are made on behalf of the Panel as a whole.

Our first day of evidence was the 28th of June 2022, two years and nine months ago, and we started appropriately with the evidence from the sister of a much loved brother who had been a patient at Muckamore for around 25 years.

As Mr. Doran has related, since then we have had a very

considerable amount of evidence and received hundreds of thousands of pages of documents. We want to thank all the relatives and patients who have helped this Inquiry by providing evidence, many of whom have I know been following these proceedings closely. 11:57

By giving evidence the relatives of patients in Muckamore gave their loved ones a voice that they would not otherwise have had. 11:57

The evidence they gave was crucial to the understanding of the Panel and we recognise that for many, probably all, the experience of giving evidence was in itself very difficult. And for others just listening to the accounts of the patient experience, the evidence which they heard must have been very harrowing for many of them. 11:57

A total of 90 witnesses gave evidence in the patient experience phase, either orally or by way of statement. More witnesses, whose accounts didn't fall directly within the Terms of Reference, were summarised and we want to thank all of them for assisting the Panel. Now, I understand that some of the Core Participants in the patient groups didn't agree with every decision that I made about the manner in which statements were to be taken, the scope of the evidence or the documentation to be received by the Inquiry. I can only say I gave careful consideration to every decision 11:58 11:58

I made and I used my best judgment to do what I believed to be right to secure the evidence we needed upon which a proper foundation for our conclusions could be founded, and I've tried to act fairly in relation to every decision that I've made. 11:58

These were highly unusual circumstances to run a public Inquiry while there is a very large police investigation and criminal trial ongoing, and successfully rebutting repeated attempts to stop this 11:59 Inquiry in light of that fact is testament to the careful approach that the Inquiry has taken in its collation of evidence and the presentation of it. Some thought we would not get to this point. We have, and I hope that the families will see that as a 11:59 vindication of their persistence in advocating for this Inquiry and it is a success in that it has allowed everyone concerned who wanted to, and who could provide relevant evidence to us, to do so and because, having completed the evidence, that now allows us to turn to 12:00 the serious work of drafting the report and the recommendations.

We also want to thank the members of hospital staff who came forward to speak of their experience at the 12:00 hospital. That included several members of staff who were critical of the management of the hospital. Some were frightened to speak but they conquered their fear so that they could come and help us and we are very

grateful for that and we know that for some of them that showed considerable courage.

We've also heard from many organisations that either had supervisory, commissioning or regulatory roles in relation to the hospital. And we heard, of course, from those directly responsible for the direct management of the hospital and for the running of the Trust. And I want, therefore, to thank each and every witness who provided evidence to us. 12:00 12:01

It is now for us to sort through this evidence and deliver a report setting out our conclusions and making recommendations.

12:01

Now, as you know, we intend to hold information sessions in relation to resettlement later this year as requested to do. That's to bring us up-to-date in relation to recent experiences of resettlement. That evidence will strictly fall outside the Terms of Reference as it will postdate 2021 and it is sought purely for the purpose of informing any recommendations that we make around resettlement. 12:01

Now we are working on how those will be conducted and those plans haven't get been finalised, but I can say they will not involve formal evidence sessions nor the full legal process of taking statements. There are different ways of providing information and we will try 12:01

to find ways to assist anyone who wants to come to speak to us. But I'm not persuaded that making that a formal legal process is the best way. Support will be offered by the Inquiry to those who wish to provide information to the Panel about recent experiences and 12:02
it is important to underline that the sessions will be entirely voluntary. If people don't want to assist us in the way that we are asking for assistance they, of course, don't have to. But we are going to cast our net beyond those who've already engaged with the 12:02
Inquiry and we're interested in hearing from a wide range of people, providing their experiences are recent and connected to Muckamore.

We've already heard a lot of evidence about the 12:03
experience of resettlement which occurred within the time frame of the Terms of Reference and we're not seeking more of the same.

Now we will publish our plans before the end of the 12:03
month. The sessions are likely to take place during the first two weeks of June. I can say that we will consider whether to allow representations to be made about the information we receive once we've received it. 12:03

Now, I know that everyone will now be waiting for the report and I can only say that I have written to the Minister For Health and indicated that I hope to have

the report with him this year. I can only promise our best efforts, there is a lot of information to take account of.

Now, I'd like to thank, on behalf of the Panel again, I would like to echo the thanks of Ms. Anyadike-Danes and Mr. Maguire and others for the great assistance given by Geraldine O'Hagan, who is no longer with us, but who did an immense amount to help families help this Inquiry and who, in her dying days, came herself to give evidence. 12:03 12:04

Can I finish by echoing the thanks of Mr. Doran to the staff supporting the Inquiry. I won't go through that long list again, but the administrative team has done an incredible job as have the solicitors and they all have the Panel's gratitude. I do particularly want to thank the counsel team and Mr. Doran himself who has exercised great judgment to help keep the Inquiry correct in matters of law. And finally we want to thank Jaclyn Richardson, the secretary to this Inquiry. Every single person in this room and every single witness from whom we've heard will have received assistance in one form or another from Jaclyn. She has worked tirelessly on behalf of the Inquiry, very often with little thanks, and so the time to thank her properly is here and now. 12:04 12:04 12:05

That concludes this hearing session. Thank you very

much indeed.

THE INQUIRY CONCLUDED