MUCKAMORE ABBEY HOSPITAL INQUIRY
RESTRICTION ORDER
PURSUANT TO SECTION 19 OF THE INQUIRIES ACT 2005

Restriction Order No. 103
(Material to be Included in Final Report)

1. I have power under section 19(1)(b) of the Inquiries Act 2005 to make orders restricting disclosure or publication of evidence or documents given, produced or provided to an Inquiry.

2. I also have power under section 20(4) of the Act to vary or revoke such orders by making a further Order in the course of the Inquiry.

3. In preparing its final report, the Panel has been mindful that Restriction Orders apply to some of the statements received in evidence by the Inquiry and to some of the oral evidence as recorded in the Inquiry transcripts. The Panel intends to refer in the report to certain material that has been subject to restriction as a result of those Orders.

4. The purpose of this Order is to vary the relevant previous Orders in order to enable publication of that material in the report.

5. The previously restricted material to which the Panel intends to refer (whether by way of direct quotation, description or summary) in the report is detailed in the Schedule appended to this Order.

6. The Schedule sets out the source of the restricted material, the actual restricted text that is to be included in the report (or, where restricted material is to be summarised or described in the report, the summary or description). The Schedule also provides references to the relevant statements, transcripts and Restriction Orders.

7. The Orders specified were made on the application of the PPS and/ or PSNI in the course of the Inquiry, in some instances on the application of individual witnesses and in some instances by me having proactive consideration of the Memorandum of Understanding between the Inquiry, the PSNI and the PPS.

8. In making those Orders pursuant to section 19 of the Inquiries Act 2005, I had regard where appropriate to the MoU and also where appropriate to the interests of individual applicants, such as the protection of a grant of anonymity. I have also had regard to these matters in making the present Order.

9. Prior to making the present Order, I have notified the PSNI and the PPS of the intended variation of previous Orders, in accordance with the Memorandum of Understanding. Where applicable, I have also notified individual applicants of the intended variation of the Order for which they applied.

10. I have considered each restricted passage (or summary/ description) specified in the Schedule. Where the relevant Restriction Order was designed to protect the investigation and prosecutions, I have considered whether publication of the limited extract concerned may have an adverse impact on the criminal process. In the case of Orders made on the application of individuals, I have considered whether publication of the limited extract may undermine any objective of the Order, including the protection of anonymity.

11. Having considered the specified text (or summary/ description) in conjunction with the relevant Restriction Orders, I am of the view that publication of this material will not undermine the objectives of the Orders. I am satisfied that the inclusion of the specified material in the report is not likely to impede, impact adversely on or jeopardise the investigation or prosecutions.

12. I therefore make this Order, in order to vary the relevant previous Orders to the extent necessary to enable the previously restricted material specified in the Schedule to be published in the report.

13. In addition to the material in the schedule, a small number of the unattributed quotes that appear throughout the report, from the relatives of patients talking about aspects of patients' lives, are derived from restricted transcripts. I am satisfied that there is no basis whatsoever on which inclusion of those quotes within the report could undermine the rationale of a Restriction Order or have any impact on the criminal process and accordingly I vary the orders in respect of these quotes to allow their inclusion in the report.

14. IT IS ORDERED that the Orders referenced in the appended Schedule are varied to enable the material specified therein to be published in the final report of the Muckamore Abbey Hospital Inquiry and that a reference to this Restriction Order be included in each of those Orders.

Made by the Chair on 18 June 2026

Tom Kark KC
Chair

1.	P36's Mother Statement	*'On occasions when visiting P36 in MAH, P36 presented with black eyes or other injuries. We were told P36 had been engaged in self-injurious behaviour and this had caused the black eyes. P36 had never engaged in self-injurious behaviour in this way before his admittance to MAH. We now wonder if these black eyes were caused by staff, or by P36 because of the stress of the abuse and neglect by staff. We do not know. At the time, we trusted that the staff were being honest, and we just accepted this but now we question everything.'*	1.17	MAHI-STM-174-19	27
2.	P21 Transcript	'*I was abused in Muckamore. I was there for six and a half years and I was on the Cranfield 1 Ward. I watched other people being abused too. The staff hit me with wet towels. The staff abused us mentally and physically. They talked to us and treated us like kids, like we did not understand. Physically, the staff would hit out at us if they could get away with it and they would say "shut your mouth.""*	1.24	Restricted Transcript – 20/09/22 – Page 19	6
3.	P21 Transcript	*'[Counsel]: 'You say you were hit on your back. Was it painful?* *[P21]: It was, yes. It was painful and, like, because it was that hard. You thought you were getting hit with a whip.* *[Counsel]: Mm-hmm.* *[P21]: So I thought I was being whipped with a whip instead of a towel.* *[Counsel]: And do you know did it leave any marks or anything?* *[P21]: It did leave a mark for about a week. And nobody did anything about it'*	1.24	Restricted Transcript – 20/09/22 – Page 49	6

4.	P54's Mother Transcript	Description in report of content of restricted text: *'P54's mother told the Inquiry that following a Freedom of Information (FOI) request she had obtained records covering the period from 2016 to 2021. There were 17 events listed, which included events when her son had swallowed batteries, suffered cuts requiring stitches and suffered broken bones requiring admission to accident and emergency (A&E) about which she had not been informed. In total there had been 24 visits to A&E. She said on almost all of those occasions she had not been made aware that her son had been taken to hospital.'*	1.26	Restricted Transcript – 13/10/22 – Pages 60-63	10
5.	P121's Sister Statement	*'P121's records state that at the time he was admitted to Antrim Area Hospital for suspected sepsis however my family were not made aware of that at the time. I was concerned that [he] was admitted to hospital so soon after being admitted to MAH. He was never unwell at home. I do not know how something could have developed on only his second day in the ward'*	1.27	MAHI – STM – 175 – 7	28

6.	P54's Mother Transcript	*'On 17th June 2022, P54 told me that staff were hurting him. He went into detail about what he was calling PI, which is physical intervention. He was crying and afraid. He named [two members of staff named], who are current staff, and demonstrated on me how they had done it. He lifted my arm, bending my hand back against my arm. I witnessed finger-shaped bruises on P54's arm. The week before he told P54's father that he had a sore leg. A member of Muckamore staff, whose name I do not know, subsequently told P54's father there's nothing wrong with his leg. I asked to see his leg, and his right leg had a massive yellow bruise. P54 said it had happened when there was physical intervention'*	1.30	Restricted Transcript – 13/10/22 – Page 47	10
7.	P121's Sister Statement	*"P121 has mentioned numerous members of staff and specific incidents to my family. He has told us that a member of staff called [named] hit him on the head and on another occasion another staff member [named] also hit him.* *P121 continuously mentions that [named] has hit him. I can only assume this is referring to [named]. P121 frequently says that a female nurse [named] hit him. He has also mentioned other staff such as [named] and [named].'*	1.30	MAHI – STM – 175 – 8	28

8.	P5's Mother Transcript	*'After 18 months being there I thought she was getting used to it. Then I got a phone call one day to say she had broken her arm. I can't recall the exact date, but maybe in 2014. She was taken to Antrim Area Hospital and went back to MAH with a plaster on it. I didn't see her until the next day after the break. I went to ask what had happened but no one seemed to know. I asked for a meeting and we went to the meeting. I could tell they were all looking at each other like "What are we going to say?" I was hard scared to do anything in case something else was done to her. I can see his face right now, the male nurse. I even said that to H40. In the meeting there was me, P5, her daddy and his wife and several MAH staff. When I asked what happened, they told me in that meeting that P5 was having a tantrum and threw herself down on the ground. P5 hadn't done that since she was 5 years old. They told us it was just one of those things because of her tantrums and behaviour, but I wasn't convinced. Everything felt all wrong. I'm not aware of any report and no support was given to me or P5, given that her arm was broken.'*	1.36	Restricted Transcript – 29/09/22 – Pages 16-17	8
9.	P5's Mother Transcript	*'P5 was very withdrawn after her arm was broken. There was constant fighting with the other girls in the ward, so I fought to get her out of Cranfield. I fought to get her into Donegore with H112. She did really well there for around 18 months and was much happier. She didn't scream down the phone anymore so I was happier. The care that H112 gave her was second to none.'*	1.37	Restricted Transcript – 29/09/22 – Page 18	8

10.	P54's Mother Transcript	*'On 24th or 25th September 2019, P54 injured his hand and broke his thumb. He required seven stitches in Antrim Area Hospital. I believe I was phoned the day the incident happened and informed by a Muckamore staff member. I cannot recall who informed me. P54 subsequently told me that a member of staff had pushed him at the nurses' station, and he lost his balance so his hand fell on top of a cup and cut his hand. This was what P54 told me during on a Monday visit on 27th September. The injury had happened on a Saturday or Sunday prior. On my Wednesday visit after the incident he told me about on 27th September 2019, P54 then told me a different story about how the injury happened. He said he had lost his balance. Every time he subsequently told the story, it changed again. Before P54 answered me about how this injury happened, he would look at the member of staff present at the time. This was very common during my visits'*	1.40	Restricted Transcript – 13/10/22 – Pages 31-32	10
11.	P52's Mother Transcript	*'I asked about medication when I became very concerned, probably again towards the latter part of her stay at Muckamore. I asked if I could have a printout, or if somebody would track back and note for me the PRN dosages and frequencies over, you know, maybe the past month I think I'd asked for. So, no. In answer to your question, I wasn't always informed about medication changes at the time, but I was never slow to ask about things when I was there or at MDTs [multidisciplinary teams] or things like that'*	1.51	Restricted Transcript – 19/10/22 – Page 109	12

12.	P52's Mother Transcript	*'H105, contacted me to say that P52 had to be put in an all-in-one suit, as she tended to take her clothes off when she became distressed. Nurse H105 thought a small further increase in P52's medication would help her to settle. I disagreed as I felt P52 needed to be less medicated. I was unaware whether further medication was administered or if my concerns were taken on board ... I tried contacting Dr H40 a few days after as I was concerned about P52's presentation following one of my visits to MAH, as she continued to appear distressed and sedated, but was unable to speak with him'*	1.52	Restricted Transcript – 19/10/22 – Page 14 and 20	12
13.	P54's Mother Transcript	*'During my visits I would ask the nurses questions about P54's care, including his missing clothes and him being drowsy. The response to queries about being drowsy would have been an allegation that P54 was "kicking off" and was administered PRN to calm him down'*	1.56	Restricted Transcript – 13/10/22 – Page 20	10
14.	P55's Father Transcript	*'I have always followed medical advice about medication and we have built up a little knowledge, as P55 has been on medication for some time. That said, we found it confusing at times, and we asked for more information about the antipsychotic medication to clarify the dosage and necessity of this medication. Dr H50 wrote the two medications on a piece of paper and threw them on the table in front of us and told us to go home and Google them. I felt at the time, and still feel, that there was something very wrong with this attitude. We felt that there were medication options which were not explored, and that there was a bit of trial and error'*	1.57	Restricted Transcript – 18/10/22 – Page 29	11

15.	P54's Mother Transcript	*'P54's father and I have raised multiple concerns over the years with H50 during meetings - I can't recall all the dates - without any response from H50. We would have been told he would come back to us on the query on medication, but he never did. It was only when we were appointed an independent advocate from Bryson House that we started to get answers with regards to P54's medication. We first appointed an independent advocate in 2020'*	1.59	Restricted Transcript – 13/10/22 – Page 41	10
16.	P21's Transcript	*'[Counsel]: 'Can you tell the Inquiry why you think you were given that PRN?* *[P21]: Because I asked for help, they thought I was too high ... I asked for something like help with something to put together and they said no ... I was asking for help, and they said "oh, he's very high", because I was getting frustrated, not being listened to'*	1.64	Restricted Transcript – 20/09/22 – Page 53	6
17.	P21's Transcript	*"P33 was very slow at eating and they rushed him. The problem is that he chokes. He has an issue with choking when he swallows. He was a good guy, but the staff took his food away from him and starved him. If he was not finished, they would take the food away and did not give him anything else to eat. When P33 came up late for dinner, there was nothing left for him. That applied to everybody. If you missed dinner, there was nothing left for you, even if you were busy with your parents'*	1.83	Restricted Transcript – 20/09/22 – Page 29	6
18.	P5's Mother Transcript	*'They were like bribing her with food as well. So, she had maybe had her food that day, they were bringing her back over and then she wanted more, you know, because of her behaviours'*	1.84	Restricted Transcript – 29/09/22 – Page 25	8

19.	P121's Sister Statement	*'P121 is dependent on MAH to brush his teeth properly and for his oral hygiene generally. I believe that the removal of his teeth occurred due to poor diet and dental hygiene at MAH. My family are concerned about dental neglect and believe his teeth may even have been filed because they are shorter than they used to be. I have a picture to evidence this at Exhibit 14. When I asked staff about this the staff member [named] said, "I am not a dentist". I asked if they brush his teeth every day as they are very dirty and they said no, due to P121 being difficult and resisting'*	1.92	MAHI – STM – 175 – 18	28
20.	P54's Mother Transcript	*'Whilst at Muckamore, P54's teeth have been badly neglected. His toenails are not cut and his feet are terrible. He went to the dentist every six months without fail whenever I looked after him. I went to Omagh for orthodontist appointments. P54 does not now have a general practitioner. I do not understand how people who are supposed to be caring for my son in a hospital cannot attend to his basic needs such as his dental and podiatry needs'*	1.92	Restricted Transcript – 13/10/22 – Page 65	10
21.	P36's Mother Statement	*'It should also be noted that on many occasions it appears that P36 spent the majority of his waking hours sitting at the table in the dining area, not at day care and not getting any meaningful activity or fresh air. There appears to have been no effort to give P36 activities when P36's night became his waking time'*	1.102	MAHI – STM – 174 – 23	27
22.	P5's Mother Transcript	*'During the last year of P5 being in MAH, £1,000 was given to H113 by P5's father. When she left MAH I was given £12 and did not receive any receipts for the rest of the £1,000'*	1.105	Restricted Transcript – 29/09/22 – Page 21	8

23.	P122's Transcript	Description in report of content of restricted text: *'Historically patients wore communal hospital clothing, selected daily from a store cupboard'*	1.112	Restricted Transcript – 28/09/23 – Page 9	22
24.	P54's Mother Transcript	Description in report of content of restricted text: *'Some patients had a condition known as pica, which caused them to put indigestible non-food items into their mouths and ingest them, but this happened on several occasions'*	1.124	Restricted Transcript 13/10/22 – Page 60 – 63	10
25.	P52's Mother Transcript	Description in report of content of restricted text: *'Some patients had a condition known as pica, which caused them to put indigestible non-food items into their mouths and ingest them, but this happened on several occasions'*	1.124	Restricted Transcript 19/10/22 – Page 27;42 & 65	12
26.	P68's Brother Transcript	Description in report of content of restricted text: *'One patient, P68, was supposed to be on close supervision while eating (a member of staff within arm's length) to prevent him putting inappropriate things in his mouth. He was found in pain and vomiting. X-rays showed he had a teaspoon lodged in his gut, perforating his bowel, and he subsequently died. While staff claim to be unaware of him ingesting the teaspoon, it could only have happened if the supervision had been relaxed.'*	1.125	Restricted Transcript – 30/11/22 – Page 128	13

27.	P52's Mother Transcript	*'On 13th February 2020, while maintenance works were being carried out on the ward, P52 was not being supervised properly by MAH staff and was able to get into a cupboard that had been left open and ingested a cigarette and tissues. H275 reported this incident to me. I took these matters to H301, the interim director of Adult and Social Primary Care of the Belfast Trust by e-mail, who had recently become involved with management at MAH. A copy of this e-mail is attached at Exhibit 13. My experience now was that the Trust were putting new people into authority positions at MAH to try to fix a very broken hospital. Staff were leaving and the gaps in provisions were very obvious. P52's care remained inadequate and she remained extremely vulnerable'*	1.126	Restricted Transcript – 19/10/22 – Page 65	12
28.	P27 Transcript	*'I was made to look after a certain patient, clean him, shower him and dress him right and bring him down. Then I was told to clean up the faeces in that room. I was given a room where there was a dangerous patient on his own. He urinated, covered it. I had to go in there on my own. Staff took him out of the side room where he was kept in and put him in another room. I went in there, no staff watching me. That boy's room was never locked while I was in his room cleaning. Faeces everywhere, urine, tablets, and I had no ever – I only had gloves, no aprons to protect myself'*	1.137	Restricted Transcript – 11/10/22 – Page 31	9
29.	P121's Sister Statement	*'MAH social worker/Adult Safeguarding said that P121 caused the bruising all down his back himself. At this point my family felt at a loss. We felt that the people who abused P121 had gotten away with it. Every concern was dismissed or not taken seriously. The thought of how, why and by what method these serious injuries were inflicted on P121 causes deep torment to my family'*	1.140	MAHI – STM – 175 – 17	28

30.	P36's Mother Transcript	*'P36 was put on a one to one in Cranfield ward, P36 thrived. He became totally relaxed and happy. He received great care and attention. He was brought out to play on the swing and for walks by people who appear to have taken him by the hand, smiled at him and accepted him. His 24 hour clock was fixed. He went to bed and got up [after a] proper night's sleep. It was a delight to see'*	1.148	Restricted Transcript – 10/10/23 – Page 105	27
31.	P36's Mother Transcript	*'On occasions when visiting P36 in MAH P36 presented with black eyes or other injuries. We were told P36 had been engaged in self-injurious behaviour and this had caused the black eyes. P36 had never engaged in self injurious behaviour in this way before his admittance to MAH. We now wonder if these black eyes were caused by staff or by P36 because of the stress of the abuse and neglect by staff'.*	1.149	Restricted Transcript – 10/10/23 – Page 123	27
32.	P36's Father Transcript	*'There were some staff at MAH who did interact with P36. For example, one care worker did model construction on one occasion and painting on another with P36. Also in the early stages, P36's named nurse, H140, introduced Makaton Symbols and a Velcro 'Now/Then: First/Next' board in P36's bedroom. I am unaware of anyone else who attempted to develop communication approaches with P36'*	1.157	Restricted Transcript – 10/10/23 – Page 84	27
33.	P36's Mother Statement	*'P36 was put on a 1:1 in Cranfield Ward. P36 thrived. He became totally relaxed and happy. He received great care and attention. He was brought out to play on the swing and for walks by people who appear to have taken him by the hand, smiled at him and accepted him. His 24-hour clock was fixed. He went to bed and got a proper night's sleep. It was a delight to see'*	1.175	MAHI-STM-174-8	27

34.	P36's Mother Statement	Description in report of content of restricted text: *'He was subsequently readmitted as a voluntary patient on various occasions until 2018. Those later admissions, however, revealed issues with staff ensuring his food was appropriately prepared and presented, and included two episodes of choking on unsuitable food'*	1.176	MAHI-STM-174-12	27
35.	P55's Father Transcript	*'[In February 2016], we were informed that a bed had become available, and P55 was admitted under the Mental Health (Northern Ireland) Order 1986. P55's mother and I were only offered MAH as an option for treating and caring for P55. No other care facility or treatment centre was explored or offered to us. We felt that P55's admission to MAH was the right thing at that time to provide appropriate treatment and to keep our son safe. From discussions with the care team, we were made to believe that P55 would be at MAH for between six to eight weeks and that, during this time, P55's medication would be managed and stabilised ... Following this, we thought that we would get our son back and that he would have a better quality of life'*	2.25	Restricted Transcript – 18/10/22 – Page 20	11

36.	P55's Father Transcript	*'We knew that the only way we could have our son return home was to have the extra help in our home, be that in the form of a domiciliary care package, which we thought was the only option at that time available. But it ended up that subsequently we went down the line of direct payments when it was eventually explained to us. But I feel earlier on in some of the meetings, not all of our opinions maybe were listened to. As far as having P55 home, it was as if they could not source the domiciliary care package, so in so many ways it was looking as if maybe P55 was going to have to have a placement somewhere, and we didn't -- we always made it clear we didn't want to go down that line'*	2.63	Restricted Transcript – 18/10/22 – Page 91	11
37.	P55's Father Transcript	*'From discussions with the care team, we were made to believe that P55 would be at MAH for between six to eight weeks and that, during this time, P55's medication would be managed and stabilised. I cannot recall who said this to us. Following this, we thought that we would get our son back and that he would have a better quality of life'*	3.6	Restricted Transcript – 18/10/22 – Page 20	11
38.	P55's Father Transcript	*'When I visited P55 on the men's ward and later in PICU [Psychiatric Intensive Care Unit], I recall on several occasions P55 would have been sitting and being very drowsy, almost falling asleep. At the time I thought this must be the side effects of the new medication'.*	3.9	Restricted Transcript – 18/10/22 – Page 22	11
39.	P52's Mother Transcript	*'I asked about medication when I became very concerned, probably again towards the latter part of her stay at Muckamore. I asked if I could have a printout, or if somebody would track back and note for me the PRN dosages and frequencies over, you know, maybe the past month I think I'd asked for. So, no. In answer to your question, I wasn't always informed about medication changes at the time'*	4.8	Restricted Transcript – 19/10/22 – Page 109	12

40.	P55's Father Transcript	*'On reflection, on some occasions we were treated as equal partners during these discussions. However, we feel in general that our informed views and opinions were not always listened to or acted upon'.*	4.10	Restricted Transcript – 18/10/22 – Page 34	11
41.	P96's Father Statement	Description in report of content of restricted text: '*A response to a parent's queries elicited that, in relation to the patient's 53 recorded seclusion episodes between July 2017 and September 2018, documentation had complied with interim guidance on DoLS issued by DHSSPS in 2010, but no assurance could be given that all seclusions had been recorded.'*	4.44	MAHI – STM – 166 – 100	29
42.	P52's Mother Transcript	Description in report of content of restricted text: *'The Inquiry identified multiple instances of a lack of adherence to care plans by staff. The Inquiry was told of one patient whose care plan appeared to contain information relating to a different patient.'*	4.62	Restricted Transcript 19/10/22 - Page 31	12
43.	P52's Mother Transcript	Description in report of content of restricted text: *'The same patient was meant to be on one-to-one supervision according to the care plan, but was able, according to her mother, to swallow a coin and ingest part of an incontinence pad.'*	4.62	Restricted Transcript 19/10/22 - Pages 27, 31 and 3	12
44.	P55's Father Transcript	Description in report of content of restricted text: *'The Inquiry heard that many families were simply told that admission to MAH was best, without discussion of alternatives.'*	5.3	Restricted Transcript – 18/10/22 – Page 20	11
45.	P54's Mother Statement	Description in report of content of restricted text: '*Operational decisions such as ward closures and patient movement were frequently made without consultation'*	5.12	MAHI – STM – 065 – 10	10

46.	P55's Father Statement	Description in report of content of restricted text: *'Families of patients at MAH often served as long-term carers and held deep knowledge of their loved ones' needs, routines and behaviours, helping them to manage day-to-day activities.'*	5.14	MAHI – STM – 066 – 6	11
47.	P55's Father Transcript	*'On reflection, on some occasions we were treated as equal partners during these discussions. However, we feel in general that our informed views and opinions were not always listened to or acted upon'*	5.26	Restricted Transcript – 18/10/22 – Page 34	11
48.	P5's Mother Transcript	*'During the last year of P5 being in MAH, £1,000 was given to H113 by P5's father. When she left MAH I was given £12 and did not receive any receipts for the rest of the £1,000'.'*	6.7	Restricted Transcript – 29/09/22 – Page 21	8
49.	P110's Mother Transcript	Description in report of content of restricted text: *'Several families told the Inquiry that patients had significantly less in their accounts than the family expected when they were discharged, despite years of benefit payments'*	6.8	Restricted transcript – 28/09/23 – Page 32	23
50.	P54's Mother Transcript	Description in report of content of restricted text: *'Some families alleged that the cash they brought in for patients was used to buy unhealthy snacks, takeaways or cigarettes, sometimes in quantities exceeding personal use.'*	6.12	Restricted Transcript – 13/10/22 – Page 26	10
51.	P54's Mother Transcript	Description in report of content of restricted text: *'They reported that personal clothing and bedding and toys also went missing.'*	6.14	Restricted Transcript – 13/10/22 – Page 19	10

52.	P122's Transcript	*'Another punishment was to be put in the seclusion room, which was a square padded room with a window that you could not open. There was a mattress and pillow, but you were not allowed to lie down during the day. If you did, the staff would bang on the door and tell you to get up. They would take your shoes off and you were supposed to just sit there. Sometimes there would have been a chair instead of a mattress. There was no toilet in the room, not even a bucket, and there was no water. If a patient wet or soiled themselves, they would have to clean this up'*	7.33	MAHI-STM-162-3	22
53.	P52's Mother Statement	*'At the beginning of June 2018, I received a telephone call ... letting me know that P52 had been given 40 milligrams of Diazepam and taken to seclusion. I was not given a reason why ... I was very concerned about the amount of Diazepam given to P52 ... On 22nd November 2018, I received a telephone call to say that P52 had been placed into seclusion for an hour and a half, but no reason was given as to why'.'*	7.45	MAHI – STM – 068 – 22	12
54.	A11's Statement	Description in report of content of restricted text: *'The consequence appeared to be that some staff defended their actions (recorded on CCTV) as an appropriate response to patient aggression, although an independent MAPA viewer deemed their behaviours to be inappropriate.'*	7.76	MAHI – STM – 269 – 44	83
55.	Eilish Steele's Statement	Description in report of content of restricted text: *'Some staff told the Inquiry that they were aware of instances over many years where restrictive practices had been misused and action had been taken. They shared examples of where colleagues had reported abuse and poor practice, resulting in dismissals, criminal prosecutions and disciplinary sanctions.'*	7.80	MAHI – STM – 260 – 62	79

56.	A5's Transcript	Description in report of content of restricted text: '*One of the social workers responsible for watching the CCTV footage from March to September 2017 reported a high level of inappropriate use of seclusion on PICU and that this was not being accurately recorded. The social worker suggested that it was being used punitively:* *'In MAH, it was seen on 2017 CCTV and clearly evidenced that the use of seclusion was too often misused by staff, most frequently used as a punitive action against patients and the recording and reporting mechanisms were completely dysfunctional"*	7.83	Restricted Transcript – 07/02/24 – Page 79	37
57.	P54's Mother Statement	Description in report of content of restricted text: *'Many families were taken by surprise by the extent to which restrictive practices were seen on CCTV footage shown to them by the PSNI. They reported not being informed about the frequency of PRN medication administration, nor when the PSNI had been called to assist in restrictive practices.'*	7.85	MAHI – STM – 065 – 24-27	10
58.	P117's Mother Transcript	*'P117 suffered an injury to a finger on her right-hand which was badly bruised [in February 2010] ... The ward manager ... told us that it had happened while staff were applying a restraint, which was permitted ... We followed procedure and made a complaint ... To date neither I nor my husband have seen any investigation or report on this incident and do not know what happened with regards to our complaint'*	7.86	Restricted Transcript – 10/10/23 – Page 29	26

59.	P121's Sister Statement	*'P121 would say to me "no dark room" and "no locked doors" and I believe this is in relation to the seclusion room in MAH. There was never an explanation as to what the seclusion room was for or how it is meant to be used. My family and I are very concerned about the use of seclusion on P121. He does not like locked doors or the sound of alarms or lots of staff coming at him and these things will unsettle him. He does not like PICU where the seclusion room is located and if he is led out to that corridor he will fight against staff and say "no ICU". In May 2018 P121 was dragged to the seclusion room. This was around the same time that my family noticed his fingernails were coming off. On occasion when we raised issues about injuries to P121's hands, staff would say that he had been put in the seclusion room and that he was knocking on the window or door and that's how he injured his hands. On the same note a nurse called H681 advised P121 could not have injured his hands by knocking on the window or door as they were padded in the seclusion room'*	7.88	MAHI – STM – 175 – 15	28
60.	Margaret Flynn's Statement	*'We heard that he'd been assaulted by the staff. I asked when and was told "two weeks ago". We had daily calls about routine matters – his meds up, meds down and yet when he's assaulted, they don't phone me for two weeks… We were visiting three times a week, telephoning and yet they said nothing… this is a breach of trust'*	8.31	MAHI – STM – 108 - 16	14

61.	P121's Sister Statement	*'My family have made numerous complaints. We have complained in person, asked the nurse in charge about injuries, challenged staff during update calls, and if not satisfied, request to speak to senior management. Usually, we are ignored. A few times we have made formal complaints to BHSCT. We would then be given leaflets on how to make a complaint, but no one would talk us through the process. No one has explained what the safeguarding process is, and this is still unclear. I have heard of serious adverse incidents (SAIs), but BHSCT has not explained this. No one has ever explained that the incidents that have happened could be reported as SAIs'.*	8.32	MAHI – STM – 175 – 25	28
62.	P54's Mother Transcript	*'As a result of SW1's involvement, we discovered weekly ward meetings were occurring and were not being notified to myself or P54's father throughout P54's time at Muckamore. The minutes were also not shared . For meetings I was notified of, H50, Muckamore, also often tried to exclude P54's father from the meetings and wanted me to attend on my own. I think they felt I would be less likely to challenge them. This continued until we were appointed an independent advocate by Bryson House in early 2021. At the six weekly meetings which we have attended since January 2022, I have raised issues such as: A lack of communication, P54's personal hygiene, the condition of P54's feet, the condition of P54's and teeth, all of which were not actioned. I always said Muckamore have something to hide'*	8.46	Restricted Transcript – 13/10/22 – Page 46	10

63.	P54's Mother Transcript	*'I feel I have not been supported by Belfast Health and Social Care Trust. I have a motto, "The Trust cannot be trusted". However, the exception to this is the help and support I received from my family liaison social worker team of SW1, H238 and another individual, helping to go through the mountain of reports and other information I have. They have given me endless support. I feel without them I never would have been able to provide the Inquiry with so much evidence of the trauma to my son, and to me as a mother, since P54 walked through those dreadful doors in 2011 to Muckamore'.*	8.46	Restricted Transcript – 13/10/22 – Page 66	10
64.	P96's Father Statement	*'On my way to the meeting with ... I contacted Regulation and Quality Improvement to advise them that my son had been assaulted at MAH. The RQIA initially said that they found this hard to believe. I then had to explain that it was not me saying this, it was what MAH had reported directly to me. The person from the RQIA called Karen Magill then telephoned - at MAH. She telephoned back 20 minutes later to acknowledge that it was true. The RQIA is the regulator and I found it very concerning that an RQIA inspector would be immediately sceptical of my complaint. They were dismissive of what I was telling them until the management of MAH confirmed it was true. In my view much of what happened in MAH hinged on the lack of proper oversight and I have serious concerns about the approach of RQIA'.*	8.47	MAHI – STM – 166 -8	29

65.	Eilish Steele's Statement	Description in report of content of restricted text: *'A long-serving nurse manager at MAH told the Inquiry that she recalled a number of incidents of alleged abuse from the 1980s up to the 2000s. One case in the early 1980s resulted in a conviction and jail sentence. In addition, three staff were dismissed from Moylena Ward in 1989 or 1990 and as a result there was a roll-out of restraint training. In the 1990s a member of staff was found to have manhandled a patient, despite his training. Another went on trial in the Crown Court but was found not guilty due to lack of evidence. She also recalled that one member of staff was dismissed in the early 2000s and another in 2005 or 2006.'*	9.13	MAHI – STM – 260 – 62	79
66.	P68's Brother Statement	Description in report of content of restricted text: *'Also in 2014, another healthcare assistant was charged with assaulting a patient, but the case was dismissed in the magistrate court.'*	9.33	MAHI – STM – 019 – 2 - 5	13
67.	A11's Statement	Description in report of content of restricted text: *'An adult safeguarding strategy meeting was convened on 25 September 2017 to review actions taken and to plan next steps.'*	10.24	MAHI – STM – 269 – 11	83
68.	A5 Statement	Description in report of content of restricted text: '*The DAPOs' recollections were that external viewers continued to be used until December 2019.'*	10.41	MAHI – STM – 196- 20	37

69.	A5 Statement	Description in report of content of restricted text: *'The PSNI complained that it did not receive Management of Actual or Potential Aggression (MAPA) expert opinions on events on CCTV footage. This was eventually rectified in 2020.'*	10.41	MAHI – STM – 196 – 22	37
70.	A7 Statement	Description in report of content of restricted text: *'They also felt that they were justified at times in watching 'clips' they had not been directed to by external viewers. For example, when one DAPO was trying to check whether a particular patient had been supervised at breakfast, she noticed that sheets and duvets were being used by staff. This prompted her to review night-time footage, whereupon she found that all the night staff were taking turns to sleep. However, she was criticised by her line manager for viewing sections of CCTV that had not been referred to her by the external viewers, presumably on the grounds that it was outside the CCTV policy.'*	10.43	MAHI – STM – 203 – 12	39
71.	A7 Statement	'*The CCTV footage showed a lot of concerning behaviour by the staff. It showed patients being dragged, kicked and pushed. Our investigation identified large numbers of staff who we referred to PSNI for investigation. There appeared to be a total disregard for patients on the PICU ward and no individual patient support. From what I saw, there was little mental or physical stimulation for the patients on the wards by the MAH staff. Staff ignored the patients which appeared to lead to escalation'*	10.44	MAHI – STM – 203 -12 - 13	39

72.	A7 Statement	Description in report of content of restricted text: *'DAPOs reported that they sometimes observed patterns of what they regarded as concerning conduct and behaviour on CCTV footage. One example was of an apparently established staff routine in PICU, whereby staff set up a mealtime table for themselves. This included some degree of ceremony in that a white paper tablecloth was used and staff sat around the table together to eat a meal. Patients who approached staff during this mealtime were pushed away.'*	10.45	MAHI – STM – 203 -13	39
73.	A7 Transcript	'*But I certainly can say, even in those wide range of staff, there were certain names when we realised they were on duty we thought we were probably going to see some really, really awful things, and we did'*	10.47	Restricted Transcript – 20/02/24 – Page 61	39
74.	A11 Transcript	'*There was no correlation between the incidents occurring and what had been reported through the Datix so most of the incidents that occurred were not reported on Datix and therefore there was no paper trail that they had actually happened. So the only evidence that we had and knowledge of them was what was viewed on CCTV'.*	10.48	Restricted Transcript – 08/10/24 – Page 16	83
75.	A7 Statement	Description in report of content of restricted text: 'T*hey also reported feeling unwelcome in the MAH coffee shop and on the wards. On one occasion, a DAPO was spat at in the car park at night by a group of MAH staff'*	10.50	MAHI – STM – 203 -19	39

76.	A5 Statement	Description in report of content of restricted text: *'Following the PSNI intervention, CCTV viewing was subsequently moved to a health centre in Belfast, ensuring that viewing took place outside MAH.'*	10.50	MAHI – STM – 196 – 24	37
77.	A7 Statement	Description in report of content of restricted text: *'Several DAPOs highlighted that in the early days the DAPOs could not access CCTV footage independently. Rather, CCTV was given in 'chunks' or 'blocks' to external viewers by Brendan Ingram'*	10.51	MAHI – STM – 203 – 8	39
78.	A5 Statement	Description in report of content of restricted text: *'DAPOs were concerned that the independence of the process of CCTV review and its findings were compromised, given that Brendan Ingram was working in MAH, although this was required at that time by the CCTV policy as he was the business manager. Another DAPO seconded to the Belfast Trust's Adult Safeguarding Historical Investigation Team, reported that there were concerns that Brendan Ingram was triaging the viewing sheets himself, and in some cases downgrading their seriousness and that some viewing sheets were not being passed to DAPOs that should have been.'*	10.52	MAHI – STM – 196 – 45-48	37
79.	A7 Statement	Description in report of content of restricted text: *'On 18 December 2018, DAPOs were told to stop reviewing the CCTV, which led to a break in viewing. They were not given an explanation for this stoppage.'*	10.53	MAHI – STM – 203 -19	39

80.	A7 Statement	Description in report of content of restricted text: *'On 08 February 2019 PSNI removed the CCTV footage, causing some further delay to the DAPOs' review.'*	10.53	MAHI – STM – 203 -19	39
81.	A7 Transcript	Description in report of content of restricted text: '*Difficult meetings ensued between the DAPOs and Mairead Mitchell in relation to whether CCTV viewing of PICU, Sixmile and Cranfield was finished, as Brendan Ingram had said'*	10.53	Restricted Transcript – 20/02/24 – Page 42	39
82.	A7 Transcript	Description in report of content of restricted text: *'It was not until 25 February 2019 that CCTV viewing restarted, now at Antrim Police station.'*	10.54	Restricted Transcript – 20/02/24 – Page 22	39
83.	A7 Transcript	Description in report of content of restricted text: *'There was an inevitable backlog of footage to review. This amounted to 80 to 90 viewing sheets.'*	10.54	Restricted Transcript – 20/02/24 – Page 45	39
84.	A13 Statement	Description in report of content of restricted text: *'A13 was a senior social worker, asked to return from retirement in 2018 to assist BHSCT as a family liaison officer (FLO). A13 was asked to work closely with the PSNI and to rebuild broken relationships with the patient families in whatever way they could'*	10.54	MAHI – STM – 255 – 4	75

85.	A13 Statement	Description in report of content of restricted text: *'They described the Phase 1 DAPO team as working under 'immense pressure' with very limited support and resources from BHSCT'*	10.54	MAHI – STM – 255 -7	75
86.	A5 Statement	Description in report of content of restricted text: *'The Phase 2 team viewed the CCTV at a new location, Musgrave Park Hospital'*	10.56	MAHI – STM – 196 – 13	37
87.	A5 Statement	Description in report of content of restricted text: *'was managed by a new BHSCT senior management adult safeguarding team and reported directly to the Executive Director of Social Work. However, they reported that they received very little handover from the Phase 1 team.'*	10.56	MAHI – STM – 196 – 14	37
88.	A5 Statement	Description in report of content of restricted text: *'It was felt that a decision had been made to keep the two teams very separate'*	10.56	MAHI – STM – 196 – 27	37
89.	A5 Statement	Description in report of content of restricted text: *'External viewers screened CCTV footage before passing flagged incidents to DAPOs. There was a team of 17 external viewers in summer 2019.'*	10.56	MAHI – STM – 196 – 62	37

90.	A13 Statement	Description in report of content of restricted text: *'A FLO working in 2019 also had serious concerns about the effectiveness of the Phase 2 DAPO team, noting that the team had no one available from the Phase 1 team who would be able to bring their extensive insight and experience of viewing footage to bear. There was also clear tension between what FLOs wanted to be able to share with families but they had to leave to the PSNI so as not to interfere with the police investigations. The FLO reported feeling discouraged from working too closely with the PSNI's FLOs and officers in charge of Operation Turnstone.'*	10.58	MAHI – STM – 255 – 13	75
91.	A13 Statement	Description in report of content of restricted text: *'They also felt that on occasions they were being asked by BHSCT managers to minimise the extent of the abuse suffered by patients. The FLO described a tangible atmosphere of mistrust, secrecy, control and unprofessional conduct with the management of Phase 2.'*	10.58	MAHI – STM – 255 – 18	75
92.	A11 Transcript	Description in report of content of restricted text: *'Other DAPOs recall this 'lower threshold' occurring much earlier in 2017, although the official policy did not change at this time. The net result was a large increase in the DAPOs' volume of work:'*	10.63	Restricted Transcript – 08/10/24 – Page 29	83

93.	A5 Statement	Description in report of content of restricted text: *'In April 2020, Phase 2 senior managers were replaced and Phase 3 commenced.* *This followed serious concerns about antagonism between the senior management members of the adult safeguarding team and BHSCT's HR team.'*	10.66	MAHI – STM – 196 – 21	37
94.	A5 Statement	Description in report of content of restricted text: *'There were also reports of antagonistic relationships between senior management on the adult safeguarding team and the PSNI. Specifically, there was reluctance to share footage with HR in relation to protection plans, despite the fact that HR was responsible for these.'*	10.66	MAHI – STM – 196 – 22	37
95.	A5 Statement	Description in report of content of restricted text: *'DAPOs found it very difficult to get the assistance required in identifying relevant staff members on CCTV footage.'*	10.67	MAHI – STM – 196 – 53	37
96.	A5 Statement	Description in report of content of restricted text: *'To their surprise, an additional staff member, H308, had been asked to gather information as part of the CCTV investigations. H308 was based in a separate office at MAH. This was only discovered when DAPOs sought to get information on how patient doors locked, as some bedroom doors seemed on CCTV footage to be used as informal seclusion rooms. Prior to this, DAPOs knew nothing of H308 and vice versa.'*	10.67	MAHI – STM – 196 – 54	37

97.	A5 Statement	Description in report of content of restricted text: *'There appeared to be reluctance for some cases to be referred to the PSNI. P36 was given as an example. CCTV footage revealed that this patient had been repeatedly neglected, seated in front of an uneaten meal, including overnight.'*	10.67	MAHI – STM – 196 – 31-32	37
98.	A13 Statement	Description in report of content of restricted text: *'A13 highlighted better managerial oversight in Phase 3, when a new manager was brought in. Once the Phase 3 team was in place A13 continued to work as a FLO and liaise with PSNI. They described a better atmosphere and a culture of open communication. By May 2020, A13 was acting as the FLO to 14 families affected by CCTV revelations of abuse'*	10.68	MAHI – STM – 255 – 22 & 25	75
99.	A5 Statement	Description in report of content of restricted text: *'However, there were continuing obstacles in Phase 3. For example, it transpired that some of the electronic files had been 'lost', leaving the new manager with insufficient background information.'*	10.69	MAHI – STM – 196 – 71	37
100.	A5 Statement	Description in report of content of restricted text: *'According to DAPOs, MAH staff continued to be uncooperative. It also became apparent that the Directorate of Legal Services had advised BHSCT not to share information with PSNI.'*	10.69	MAHI – STM – 196 – 88	37

101.	A5 Statement	Description in report of content of restricted text: *'DAPOs nevertheless reported that processes were better managed. The new manager allowed FLOs to give more information to the families and to police. Around 400 forms relating to PICU were passed to the PSNI that had not yet been seen by DAPOs'*	10.70	MAHI – STM – 196 – 84	37
102.	A5 Statement	Description in report of content of restricted text: *'While DAPOs responded to these historical forms they were often too late to be included in criminal processes, as suspects had already been interviewed.'*	10.70	MAHI – STM – 196 – 85	37
103.	A13 Statement	Description in report of content of restricted text: *'A13 joined the Phase 3 team and was able to watch some of the CCTV footage. They described how it seemed that when certain groups of staff worked together on a shift, they appeared to pick on certain patients. A13 also described how, when staff realised the CCTV was operational, they changed their presentation and their behaviour.'*	10.71	MAHI – STM – 255 – 64	75
104.	A5 Statement	Description in report of content of restricted text: *'A new Collective Leadership team in June 2022 offered fresh oversight'*	10.72	MAHI – STM – 196 – 112	37
105.	A5 Statement	*'I believe there was a closed culture that prevailed in MAH that intentionally created a flawed investigative system that was designed to protect the status quo of power and control within MAH'*	10.72	MAHI – STM – 196 – 13	37

106.	A5 Statement	*'The CCTV footage which I viewed, particularly of PICU showed a culture where ill treatment of patients was normalised ... It was not the case that most of the abuse occurred out of hours in the evening or weekends when senior management were off site"*	10.72	MAHI – STM – 196 – 151	37
107.	A13 Statement	Description in report of content of restricted text: *'A13 attended a team development training day in December 2022 to explain their role and that of other family liaison social workers. They were told by MAH staff that they had been informed by management that they should not trust FLOs.'*	10.73	MAHI – STM – 255 – 34	75
108.	A5 Statement	Description in report of content of restricted text: *'At the beginning of January 2022, the Inquiry Secretary wrote to BHSCT staff to encourage them to attend further information sessions run by the Inquiry. A link to an information sheet about those sessions was attached. One FLO reported to us they had been discouraged by a manager from forwarding the link to others.'*	10.75	MAHI – STM – 196- 96	37
109.	A5 Statement	Description in report of content of restricted text: *'They were told to wait for a staff meeting, scheduled for 06 January 2022'*	10.75	MAHI – STM – 196- 96	37

110.	A5 Statement	Description in report of content of restricted text: *'The meeting, on 06 January 2022 was attended by DAPOs, FLOs and senior management, and it was joined (virtually) by lawyers acting for BHSCT and by Inquiry liaison staff, who were introduced as guest speakers. Three attendees, including a FLO, asked if the meeting could be recorded. It was indicated that this was unnecessary and that notes would be taken instead.'*	10.76	MAHI – STM – 196- 97	37
111.	A5 Statement	Description in report of content of restricted text: *'According to A5, during the meeting the FLOs were quizzed about what had happened at the engagement sessions with the Inquiry and what the Inquiry had wanted to know. It was emphasised that any dialogue with the Inquiry should only be undertaken with the 'support and protection' of BHSCT."*	10.77	MAHI – STM – 196- 100	37
112.	A5 Statement	Description in report of content of restricted text: *'It was also emphasised that any staff member was free to assist the Inquiry if they felt they could but that doing so outside the 'safety and protection' of the Trust might cause problems. Warnings were given that there was no such thing as a 'friendly chat' with a public inquiry and about difficulties that could arise if staff members were critical of the Trust.'*	10.77	MAHI – STM – 196- 105	37
113.	A5 Statement	Description in report of content of restricted text: *'Positive engagement with the Inquiry was discouraged and it was suggested that people should 'keep their head down' and wait for the Inquiry to come to them.'*	10.77	MAHI – STM – 196- 103	37

114.	A5 Statement	Description in report of content of restricted text: *'It was further suggested that families' statements were likely to be critical of the Trust and any FLO who supported a family through that process might find themselves in a 'conflict of interest'.'*	10.77	MAHI – STM – 196- 101	37
115.	A5 Statement	Description in report of content of restricted text: '*Although this may have been in part a genuine attempt to avoid accusations of interference by the FLOs in the statement-taking process, some of the comments made were taken as discouragement to the FLOs and DAPOs from being critical of BHSCT. Whether intended to be or not, the general tenor of the advice given was received as dissuasion to those present from open participation in the Inquiry. The FLO described how the meeting had a devastating effect on them and some of their colleagues, who had until then been excited and positive about contributing to the work being undertaken by the Inquiry but were now frightened of doing so.'*	10.78	MAHI – STM – 196 – 104 Transcript 8/02/24 - Page 47	37
116.	A5 Statement	Description in report of content of restricted text: *'According to the witness, written minutes of the meeting provided many months later did not reflect the tenor of the meeting. The FLO did not feel they could challenge the minutes in the circumstances and felt intimidated.'*	10.79	MAHI – STM – 196 – 105 Restricted Transcript – Page 54 – line 20	37

117.	A5 Statement	Description in report of content of restricted text: *'However, by July 2022, the contemporaneous team were also in difficulties and had a major backlog of incidents that went back to 2019. This meant that the historical team was asked to help.'*	10.86	MAHI – STM – 196 – 117	37
118.	A5 Statement	Description in report of content of restricted text: *'The contemporaneous team reported many of the same difficulties that the historical team had had. These included poor access to CCTV footage, outdated equipment, problematic relationships with MAH nursing staff and difficulties identifying staff on CCTV.'*	10.86	MAHI – STM – 196 – 122	37
119.	A5 Statement	Description in report of content of restricted text: *'Frequent staff turnover of DAPOs also made workload difficult to manage.'*	10.86	MAHI – STM – 196 – 122	37
120.	A9 Transcript	Description in report of content of restricted text: *'Many of the patients on the resettlement wards had serious physical and learning difficulties but not challenging behaviours.'*	12.5	Restricted Transcript – 21/02/24 – Page 14	43

121.	P27 Transcript	*'I was made to look after a certain patient, clean him, shower him and dress him right and bring him down. Then I was told to clean up the faeces in that room. I was given a room where there was a dangerous patient on his own. He urinated, covered it. I had to go in there on my own. Staff took him out of the side room where he was kept in and put him in another room. I went in there, no staff watching me. That boy's room was never locked while I was in his room cleaning. Faeces everywhere, urine, tablets, and I had no ever – I only had gloves, no aprons to protect myself'*	12.45	Restricted Transcript – 11/10/22 – Page 31	9
122.	James Wilson Statement	Description in report of content of restricted text: '*both of which put patients and staff at risk. Staff were focused on completing tasks rather than seeing the patient as a whole person'*	12.49	MAHI – STM – 188 -4	46
123.	A9 Transcript	Description in report of content of restricted text: *'…there were staff members that treated me differently. They communicated plainly to me and avoided my company. I felt that I was being ostracised by them for reporting what H589 did'*	14.113	Restricted Transcript – 21/02/24 – Page 28	43
124.	Paula McCann 2nd Statement	Description in report of content of restricted text: *'After I reported the incident involving H117, some MAH staff stopped speaking to me. I cannot recall their names. I felt very uncomfortable because of this, unsure of myself as part of the team, rejected and scapegoated ... I felt that I was judged and isolated by the other staff and I did not feel comfortable to raise any further issues.'*	14.114	MAHI – STM – 197 -7 - 8	48

125.	P55's Father Transcript	*'We knew that the only way we could have our son return home was to have the extra help in our home, be that in the form of a domiciliary care package, which we thought was the only option at that time available. But it ended up that subsequently we went down the line of direct payments when it was eventually explained to us. But I feel earlier on in some of the meetings, not all of our opinions maybe were listened to. As far as having P55 home, it was as if they could not source the domiciliary care package, so in so many ways it was looking as if maybe P55 was going to have to have a placement somewhere, and we didn't -- we always made it clear we didn't want to go down that line'*	15.54	Restricted Transcript – 18/10/22 – Page 91 – 92	11
126.	P121's Sister Statement	Description in report of content of restricted text: *'Yet, the Inquiry heard evidence from the sister of a former patient that no one had explained to her what detention under the MHO meant. She subsequently did not attend Review Tribunal hearings because she was under the impression that it would make no difference to the outcome.'*	18.50	MAHI – STM – 175 – 5	28