



EASY READ VERSION OF EXECUTIVE SUMMARY

Introduction

This report is about a hospital in Northern Ireland called **Muckamore Abbey Hospital**. You might have been there or know of it. It was a place where people went to be looked after. Most of the people there had **learning disabilities or autism**. They needed extra support with daily living and with learning, communicating, or understanding things.

The hospital's job was to **care for people, keep them safe, and help them live happy lives**. They should have helped people go back to their families and local community. People should not have lived in hospital for many years but many did.

What went wrong?

Sadly, something very serious happened. Some of the people who worked there who are called 'staff' **did not treat patients kindly**. Instead of helping, they sometimes **hurt, bullied, or ignored them**. Some of the patients got injured by staff. This is called abuse.

It is important to remember that **not all staff were bad**, and many people worked very hard to help patients. But enough things went wrong that **many patients were hurt or upset**, and this should never have happened.

The people staying at the hospital were often **very vulnerable**. This means they needed extra help and protection. Some of them could not

Speak or explain how they felt. Because of this, it was harder for them to tell someone if something was wrong.

That is why it was even more important for the staff to be **kind, careful, and responsible**.

How was it discovered?

In 2017, recordings from cameras (called CCTV) were looked at after someone reported a problem. These cameras showed that some patients were being **treated very badly**.

When people who managed the hospital saw the videos, they were **shocked and upset**. The news spread quickly, and it made families and the community very worried.

How did families feel?

Families trusted the hospital to take care of their loved ones. When they found out about the abuse, they felt **heartbroken, angry, and sometimes guilty**, even though it was not their fault.

Many families had already been worried. They had noticed things like:

- Cuts, bruises, or broken bones which no one explained clearly
- Their loved ones looking scared or unhappy especially when taken back to the hospital after a home visit
- Poor hygiene, like dirty clothes or unwashed hair
- Patients lost a lot of weight or got much bigger
- Some of them seemed to forget how to do things they usually did at home

Sometimes, families asked questions or raised concerns, but they didn't usually get clear answers. This made them feel **ignored and frustrated**.

They didn't get the help they needed to ask questions.

Why did this happen?

The investigation found that the problem was not just about a few staff making bad choices. There were also **bigger problems** in the way the hospital was run.

Some of these problems included:

- **Not enough staff**, which made it harder to care for everyone properly
- **Poor training**, so staff didn't always know the best way to help
- **Not enough to do** so people got bored and didn't learn new skills
- **Weak leadership by senior staff**, meaning problems were not understood or fixed quickly
- **Families not being involved** in decisions about care
- **Complaints not being taken seriously**
- Too much use of **restraint or medication** to calm patients down instead of understanding their needs

Over time, some bad habits of staff became "**normal**", even though they were not okay. This is called the "normalisation of bad behaviour."

How did this affect patients?

Because of these problems, some patients:

- Felt **scared or unsafe**
- Became **lonely or bored** because there were not enough activities
- Lost skills they once had
- Were sometimes given medicine to control their behaviour instead of being helped in kinder ways

Some patients became afraid to return to the hospital after visiting home.

What should have happened?

The hospital should have:

- Treated every person with **kindness, respect, and dignity**
- Listened carefully to patients and families
- Included families and the patients in decisions
- Made sure staff were **properly trained and supported**
- Worked out how to **help people get out of hospital** and back to their local community
- Acted quickly when something seemed wrong
- Created a safe and caring environment

What is being done now?

A big investigation called an **Inquiry** looked into everything that happened. The people running the Inquiry want to make sure that **this never happens again**.

They made suggestions (called recommendations) to:

- Improve how care is given
- Make sure patients are safe
- Include families in decisions
- Spot problems early before they get worse
- Provide better training and support for staff
- Organise management better to stop this ever happening again
- Make sure senior staff can see what care is like and work to improve it

The most important lesson

These events remind us of something very important:

Every person matters.

People with learning disabilities and autism deserve to:

- Feel safe
- Be treated kindly
- Be listened to
- Be properly supported
- Live happy and full lives

A good society is one that **takes care of the people who need the most help.**

A hopeful ending

Even though this story is sad, it has an important purpose. By learning what went wrong, people can **make things better in the future.**

The goal now is to make sure places looking after autistic people or patients with learning disabilities:

- Treat everyone fairly
- Work out how to help each person best
- Make sure no-one is hurt
- Make sure no-one is left unheard
- Involve patient's families more in their care
- And **everyone is cared for with kindness**