CHAIR'S ADDRESS

INTRODUCING THE REPORT

ISSUED ON 18 JUNE 2026

1. I want to welcome everyone who has attended today, on what is the culmination of a great deal of work by very many people. It is very fitting to launch this report today, in what those present will know is learning disability week the theme of which is 'do you see me' which is all about people with learning disabilities being seen, heard and valued.

2. At the end of this short address, I will announce the publication of the report, but I want to say a few words about the report and about those who contributed to it first.

3. This Inquiry was set up, because of the revelation that members of staff had been abusing service users at Muckamore Abbey Hospital, just 20 or so miles from where we sit today in the centre of Belfast. That hospital since 2007 has been under the management of the Belfast Health and Social Care Trust, which I will refer to from now on simply as 'The Trust'. What was most shocking was that the service users, or patients as we have been calling them, were almost all individuals who had severe learning disabilities or were autistic people. Worse still was the fact that the great majority of those individuals were non-verbal. That meant that they were particularly vulnerable to those with malign intent.

4. This public Inquiry was commissioned by the then Minister of Health, Robin Swann in 2020 after a persistent and valiant campaign by the relatives of the

many patients affected by this scandal. I was appointed to chair the Inquiry in June 2021 and we started hearing from witnesses in June 2022.

5. As we examined witnesses and heard more about the hospital, it became obvious that there were other forms of abuse and not just physical abuse of these patients, in the form of neglect, poor care, and a wider diminution of their rights, simply as a result of them being at Muckamore Abbey Hospital or 'Muckamore'.

6. I want to say a little bit about how we approached this inquiry. By 'we', I mean myself and my panelists, Dr Elaine Maxwell and Professor Glynis Murphy who have contributed so much to this inquiry and to this report through their expertise and practical experience.

7. I have set out in the Executive Summary the methodology that the Panel adopted. The terms of reference for this Inquiry were extensive, they cover a period from 1999 to 2021, but they can be reduced to some primary goals, they were these: to examine what abuse occurred within the hospital, to determine what the circumstances were that allowed the abuse to happen and to make recommendations to try to ensure that such abuse does not occur at any other similar institution providing similar services in Northern Ireland. So, this report will affect all such services in Northern Ireland and, we hope, this report will have wider implications beyond this jurisdiction as well.

8. So, the first of those tasks was to examine the abuse that occurred and 'abuse' was widely framed. It included everything one would expect to be included in such a term, not confined to physical or sexual abuse but to include neglect, inappropriate care, improper use of patient finances and other misbehaviour towards patients. So, our remit was very broad, but it has allowed us to examine the quality of patient care at Muckamore which narrower terms of reference would not have enabled.

9. In approaching this task, we have drawn together several themes which we then examined in greater detail. There were two main periods in which we

heard from the relatives of patients in sessions which we termed ‘The Patient Experience’. The themes grew out of the patient experience evidence. The first period was right at the beginning of the Inquiry, from the 28 June 2022 to 20 November 2022. We heard from 45 witnesses who came forward to tell us of their direct experience either as patients or as relatives of patients living in the hospital.

10. Between the 20 March 2023 and 28 June 2023, we heard evidence within what we termed ‘Evidence modules 1-6’, which dealt with the law around mental health and capacity, the Bamford review and its effects; policies affecting Learning Disability service users, Governance structures and the training of nurses. We heard from Professor Margaret Flynn the author of the report ‘A Way to Go’, published after the abuse had emerged. We also heard a lot about the policies surrounding the delivery of care to people with learning disabilities.

11. We then reverted to evidence from patients and relatives and between 12 September 2023 and 12 October that year, we heard from a further 43 witnesses.

12. Now those witnesses coupled with the first period of patient experience evidence, demonstrated to us that there were various themes, or strands that were consistent throughout the patients’ experience of parts of the hospital.

13. We heard about unexplained marks and injuries, we heard about bruises, grip marks, black eyes and broken bones; we heard about a lack of information given to families about how those marks and injuries had been caused, and we heard about a lack of such explanation even when patients were supposed to be under constant supervision. We heard about the inappropriate use of restraint, and the inappropriate use of seclusion. We heard about the families’ fears of complaining, in case that led to some form of retribution upon the service users in the hospital. We heard examples of a lack of personal care, of patients being inappropriately dressed, not washed, with faeces under their fingernails or on their clothes. We heard about a lack of attention to diet with patients sometimes becoming obese or losing weight dramatically and about

toenails and teeth not being looked after. And we heard about relatives visiting patients who were quite obviously overmedicated, or as some put it 'zombified'. All of these issues were related to us by loving relatives who had had to watch all of this and felt powerless to do anything about it.

14. Each of those witnesses had to give evidence about the most personal matters and things which must have worried and distressed them even more when they first discovered what had been going on via the revelations about the CCTV footage. Knowing about the revelations of abuse of individuals at Muckamore, many felt guilty about placing their relatives there. To give that evidence in the full glare of a public inquiry must have been, for most, and probably all, exceptionally difficult.

15. Some of them were giving evidence about things that had happened many years ago and so it is not surprising that details and dates were sometimes either hazy or inaccurate. But most had strong recollections of noticing problems with their relatives or seeing injuries which stayed indelibly printed in their memories and failures of recollection of details such as exact dates become less important if there is sufficient weight of similar experience as we found there to be.

16. Patients and their relatives are experts by experience and organisations that fail to listen to that experience will lose necessary and valuable information.

17. I want to thank all those who came to assist the Inquiry despite no doubt their trepidation at doing so. I hope they all appreciate now the good they did, we certainly do.

18. The next group of witnesses were the staff from the hospital. We started that period of evidence on 13 November 2023 and that took us through to the 10 June 2024 with a short break in the middle for me to have some medical treatment. We heard from another group of staff in September 2024 and in total we heard from 39 members of staff. I want to pay tribute to them as well. Some of them were very trepidatious about coming to this room, to speak about other

staff and their experiences at the hospital, and many of them were very frank about what they thought of the management of the hospital. Again, not easy for them to do and many of them showed considerable bravery coming forward.

19. It is also right to mention and acknowledge the work of the many staff at the hospital who over many years discharged their responsibilities with care and compassion and it is very sad that their good work has been tainted by the actions of others.

20. We then heard extensive evidence covering the issue of previous problems at the hospital including an investigation into the conduct of staff on Ennis ward in 2012 which ought to have raised red flags but didn't.

21. We heard from the regulators of the service, most particularly the Regulation and Quality Improvement Authority (RQIA) who spotted several issues at the hospital but never spotted that the abuse of patients was taking place. We also heard evidence from the Police Service of Northern Ireland (PSNI) and how they became involved in the investigation of abuse. We considered that evidence together with the evidence of the Trust's Designated Adult Protection Officers (DAPOs) responsible for viewing the CCTV footage.

22. Then in September 2024 we turned to the management of the hospital. We heard from the deputy chief executives, the division managers, chief executives, directors and co-directors of learning disability services and non-executive directors. We also heard from the Chair of the Belfast Trust.

23. Finally, we turned to the Department of Health, and we heard from the Chief Nursing Officer, the Chief Social Worker, the Chief Medical Officer, Directors of Social Care and two Department of Health Permanent Secretaries whose experience covered almost the entirety of the period of our terms of reference.

24. Where did all that evidence lead us?

25. Chapter 1 of the report is a long chapter devoted entirely to the patient experience. We could not possibly have recounted all of the evidence we received in the report itself, or it would have become impossibly long, but we have tried to select a significant number of the experiences which provide examples of the range of the problems that relatives and patients encountered with the quality of care at the hospital which of course includes the abuse that took place.

26. Each chapter of the report ends with a set of conclusions and in the short time I have now, it would not be possible to deal with each of those. But I will do my best to summarise just some of the headline issues. When you read the report, you will see that we have also included a series of quotes on the facing page to the first page of each chapter, that tell the reader a bit more about the lives of those who were either still living, or had previously lived, in Muckamore. We hope that these quotes assist in ensuring that, at all times, the reader is reminded that this report is about people and their lives.

27. The injuries that relatives noted were neither isolated nor incidental, they were visible marks of a systemic failure. Very often they were dismissed by staff as self-inflicted or as a result of peer-on-peer abuse. Some will have been, but by no means all. But by treating them as individual incidents and diminishing the importance and effects of peer-to-peer abuse, the Trust did massive disservice to those it was meant to be looking after.

28. Peer-to-peer abuse is an important indicator of an uncontrolled environment and a badly managed service, and dealing with incidents individually deprived the Trust of the ability to recognise patterns which, if acted upon, might have saved patients from injuries and lasting harm as well as great distress to families. The failure to act also allowed some of the staff at the hospital to slide into the normalisation of deviance. In other words, the allowance of poor practice, which led to poorer and poorer practices, until bad behaviour and mistreatment became a normality which many ignored.

29. The escalation of peer-on-peer violence as well as an increase in the use of seclusion from 2011 onwards should have been seen and understood for what it was, a warning sign and a precursor to the mistreatment of patients by staff.

30. The transition of Muckamore from a long stay placement facility to a hospital for the assessment, treatment and swift discharge of service users, may have been a sensible and appropriate change, if it had led to what the policy makers intended. Namely, those with learning disabilities and autistic people ought not to remain in such an institution for years but should live, as far as possible, in community places using their life skills wherever they could. But the policy ambition for an effective short-term assessment and treatment service was not met in reality.

31. There were insufficient community and social care placements, nor was there sufficient support to ensure placements outside hospital succeeded. There was also insufficient crisis team availability. This meant that however sensible and well intentioned the policy shift was, too many patients found themselves being readmitted after failed resettlement.

32. Within Muckamore there were chronic shortages of staff particularly from 2012. There was a failure to ensure the appropriate number of nursing staff as well as the balance of registered nurses and healthcare workers. This meant that some essential care was not delivered. There was also a shortage, over a lengthy period, of suitably qualified allied health professionals such as psychologists, occupational therapists, speech and language therapists and others, so patients' ability to cope with daily living, and their skills in doing so actually diminished for many.

33. Budget cuts, in part as a result of anticipated resettlement, led to staff recruitment freezes and the closure of activities enjoyed by patients. Although some day activities continued, they were diminished so that service users found themselves spending more time on the wards with little to do or to occupy them, and challenging behaviour was not understood as an expression of unmet needs. This led to more dysregulated behaviour than was necessary and that

in turn led to the misuse of restraint and the misuse of seclusion by staff at the hospital. It also appears to have led to the overuse of PRN medication leaving some patients at times insensible.

34. Co-production with families was lacking, so that families who most often knew them best could not contribute properly to the care of the service users and their daily lives at the hospital. Information about triggers for patients or how best to de-escalate dysregulated behaviour was not passed on, through no fault of the families concerned. This also left families feeling marginalised and excluded when in reality they had a lot to offer.

35. Families also experienced difficulties complaining. There was a lack of understanding about how to complain and a lack of support when relatives wanted to complain. Complaints when made were often dealt with at ward level, meaning that they did not feed into the knowledge base that the Trust itself had about the level of complaints. Concerns were raised, but investigations were often inconclusive because of a lack of supporting evidence, exacerbated by the fact that many patients were non-verbal and could not provide direct evidence. Relatives often had a poor experience of complaining, with investigations taking far too long and being unsatisfactorily resolved. This was made more complex and more difficult for families once the police investigation started and primacy over those investigations was handed to the PSNI.

36. Warning signs of a deeper malaise such as the Ennis ward investigation in 2012 were missed because there was a focus on individual liability and a focus on that ward, rather than examining whether the concerns raised deeper issues about the culture of the hospital more generally. Reports of significant increases in violence on the wards from 2011 onwards were explained as being the result of better reporting systems and there was a failure to assess and synthesize the available data which pointed to problems on the wards of the hospital. These warning signs if understood might have avoided what followed.

37. We looked carefully at the response to the 2017 CCTV revelations which triggered the police investigation and ultimately this Inquiry. While accepting that the management of the Trust faced a very difficult situation, the handling of the review of CCTV was poorly managed. Those responsible for reviewing CCTV were terribly unsupported and, their job was made more difficult by a lack of sensible procedures. The DAPOs ended up feeling isolated and vulnerable. They were hampered in their tasks by poor management and reviled by many of the staff within the hospital. They plainly did not get the support to which they were entitled and which they needed, to do the difficult job they were given.

38. So many members of staff had to be suspended following the viewing of CCTV that they were replaced most often with agency staff lacking specific learning disability training, leaving patients still at risk of poor care and even abuse.

39. The Board of the Trust repeatedly reassured itself that care at Muckamore was safe, compassionate and effective, but they failed to consider whether there was data that supported those assurances. The reality was that for a significant period after the CCTV revelations, Muckamore was still not a safe place to be cared for.

40. The Trust was trying to manage the fallout from the CCTV revelations at the same time as many other difficult issues, all within the context of constrained resources and rising demand. The governance structures were simply not sufficiently robust, and this contributed to an environment in which vulnerable individuals were not adequately safeguarded.

41. We examined the issue of resettlement with care and received further information in June last year to bring us as up to date as possible for the purposes of our recommendations. We found that most people who had been resettled experienced ‘betterment’ in other words an improvement in their lives, that was despite there being some significant initial resistance to the idea from some families. But after initial successes in the early days of resettlement, placements for those with more complex needs often failed and there were

multiple reasons for that including the lack of emergency intervention being available. Successful resettlement requires a constant focus on the individual service user's needs and an appropriate period to assimilate that individual into the potential new surroundings and way of life. Often a relative's close involvement in that process is critical to success. Too often this did not happen.

42. Let me turn then to the recommendations we have made. There are 106 recommendations and it is obvious that I could not even attempt to summarise each of them here. There is a danger too that I will mention some recommendations but not mention others which might give the appearance that some are more important than others and I want to avoid doing that.

43. But what I can briefly talk about is the main aim of the recommendations and just some of the headlines. They are as follows;–

43.1 A regional standing committee of people with learning disabilities, autistic people and their families should be created to be consulted by the Department of Health and other bodies on all services for learning disabilities and autistic people;

43.2 Every individual with a learning disability or autism who is admitted to any placement must have a named key individual responsible for care plans and communicating with the family concerned;

43.3 The use of medication to subdue individuals must be eliminated and better systems are needed to ensure that the use of medication is properly monitored and audited so that its use can be constantly reduced;

43.4 Those with learning disabilities need meaningful leisure and skill building activities, as well as supported employment where appropriate, and they need to be supported by sufficient allied health professionals of different disciplines;

43.5 Families need to be much closer involved in care planning and decision making. There needs to be a fundamental and meaningful shift in the practice of co-production and training needs to be delivered to staff as well as offered to families;

43.6 There needs to be a commitment across the system and at Board level to reducing the use of restraint, and a greater use of psychological input to avoid its use; any use of restraint needs to be monitored and there needs to be post incident analysis and learning;

43.7 Any use of seclusion as a restrictive practice should be an exceptional event and the subject of a serious event audit;

43.8 Organisations providing care and support for autistic people and those with learning disabilities need to be aware of the risk factors that predict the likelihood of abuse, and they need to plan how they will respond to such issues;

43.9 Families and service users need to be supported where necessary in making complaints. They need professionally trained advocates, better information on how to record problems and how to take them forward. All complaints need to be recorded electronically so that the data is available for audit and analysis to detect themes;

43.10 The use of CCTV is a difficult and contentious issue, but every facility should be considering its use and there should be appropriate consultation with families. CCTV in private areas of a facility should also be considered but should only be used when it is in the best interests of the service user. Oversight and analysis of CCTV footage should sit outside the setting in which it is recorded;

43.11 Adult safeguarding has not been given the status it requires, and it should be recognised as a Delegated Statutory Function equivalent to child protection;

43.12 There needs to be greater focus and understanding of staffing required to meet each service user's needs. There needs to be an integrated workforce plan based on the assessed needs of each service user and careful consideration needs to be given to the mix of registered and unregistered staff as well as Allied Health Professionals. All Healthcare Assistants working with service users with learning disabilities require specific training;

43.13 The education of Trust Boards for both executive and non-executive directors needs to be improved, especially in relation to social care

governance and the collective performance of Boards needs to be reviewed regularly;

43.14 Boards need to get better at receiving confidential reports from members of staff about concerning behaviour and we have made specific recommendations to improve this significantly;

43.15 When a service user is being resettled or moved there should be a key individual appointed to ensure the service user and the family are consulted and who can advise them and keep them fully informed;

43.16 There must be a statutory duty of candour imposed across the whole system. This was recommended by another inquiry in 2018, and we know the Assembly is already considering this and there are complexities to the debate but, with respect, they need to accelerate this, decide how it is to be applied and legislate urgently;

43.17 Finally, there is an issue in the current Adult Protection Bill in relation to the test to be applied when prosecuting an organisation in circumstances where one of their employees has caused deliberate harm to a patient. It is in our view too complex and difficult to prosecute in its current draft form, and we have suggested a simpler offence that is more easily provable. In order to avoid conviction an organisation would need to be able to demonstrate that they had taken all reasonable and practical steps they could to avoid the harm that occurred. That would, we think, have a significant effect on how all healthcare organisations regard risk.

44. That is a very brief summary of just some of the recommendations, but each recommendation will need careful and focused consideration.

45. Finally, I would like to address the families directly, many of whom I have met but haven't seen for some time now.

46. Today is not the end of the road in relation to what happened at Muckamore, for many of you it will just be another beginning. Many inquiries look at a single past event, or a series of past events which by the time the Inquiry starts, have finished. But this Inquiry is a little different. We know that every day of your

lives you have been fighting to make the lives of your child or sister or brother safer and better. We know that there are still allegations of abuse at other facilities in Northern Ireland.

47. We recognise that your fight has not ended because you will continue in your struggle to get the best for the people you love.

48. This report should be a powerful tool to assist you. You may not agree with everything in it, you may have wanted more from it. I can say that our conclusions and recommendations are all supported by the evidence we heard, they are practical, doable and effective. So, I ask you to use this report and the significant effort that has gone into it from so many different people to good effect.

49. I have no doubt you will keep the pressure on the politicians and the Department of Health, and all those organisations identified in the report and in its recommendations. You have power to make your voices heard and this report is intended to help you to be heard.

50. One final note in relation to the future. As you may have seen in the executive summary, we do not specifically address in detail the issue of redress for individuals. Importantly, however, we do recommend that the Department of Health should set up a working party to consult patients, service user groups and the families of those who have suffered abuse at Muckamore. That will ensure that the issue of redress to meet the needs of victims of abuse can be considered and looked at in a properly focused manner.

51. Looking beyond this report, I have thought about whether there is anything we could do for those with learning disabilities and people with autism, to acknowledge what happened at Muckamore and whether there is any initiative we could support to mark the closure of this Inquiry. I have been in discussion with Antrim Castle Gardens. Many of you will know them. They are relatively close by and beautiful, they very well adapted for those with disabilities. They have two sensory gardens. They have been very accommodating and I am

very hopeful that a special place can be created there for anyone with learning disabilities and particularly for those who have experienced life at Muckamore Abbey Hospital.

52. I can now formally say that the report is published and the restrictions on reporting are now lifted. An electronic copy of the report will shortly be available on the Inquiry Website together with an Easy Read version of the Executive Summary. I hope the Department of Health will ensure that the report is available via their website and that the Belfast Trust will do the same.

53. In order to allow for the privacy of others and to respect the emotional impact that today will have on many of those attending, may I ask that no media interviews are conducted within the premises nor immediately outside the front door to allow people who wish to, to leave without public attention.

54. That concludes this hearing, thank you again.

END